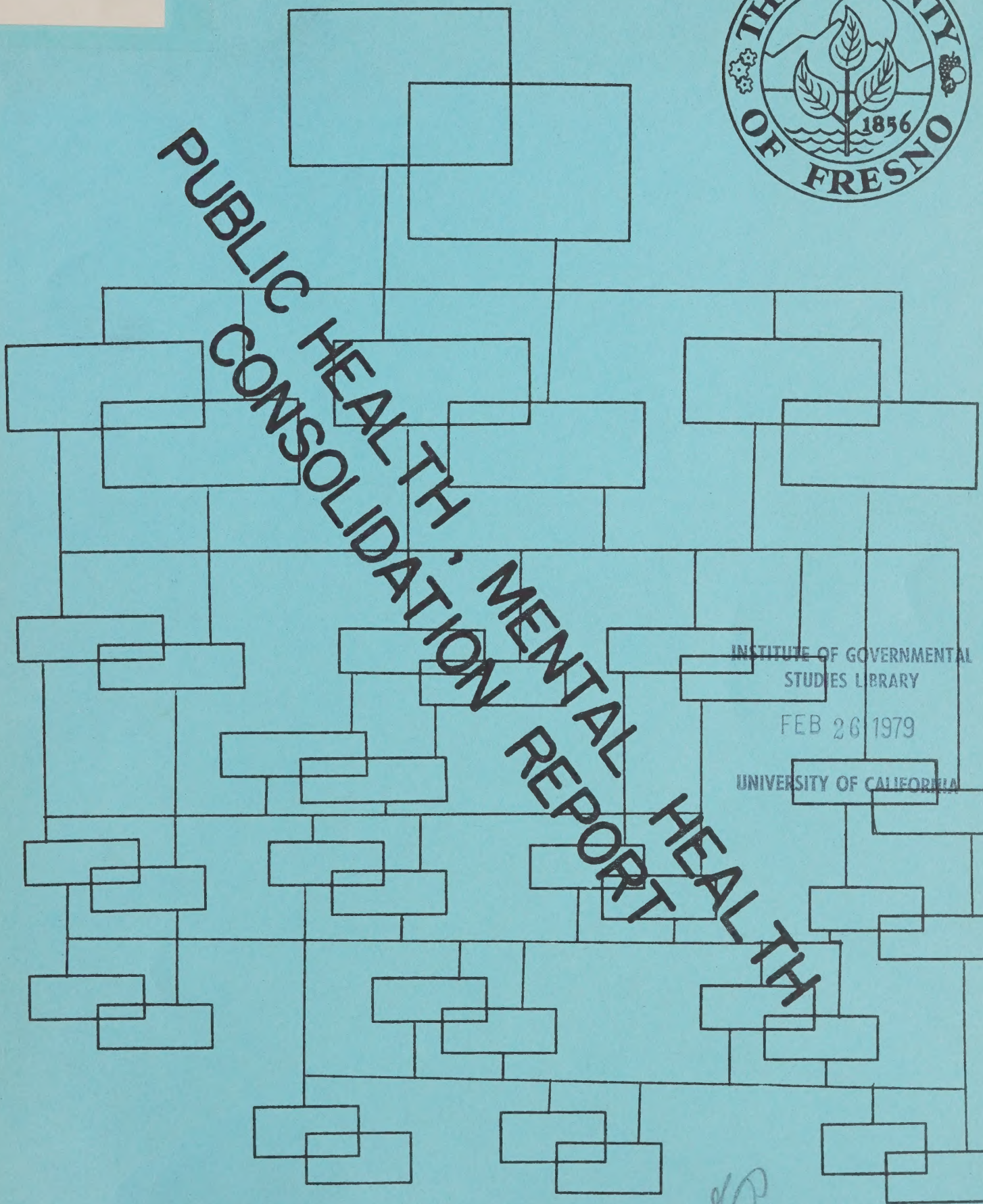

PUBLIC HEALTH, MENTAL HEALTH CONSOLIDATION REPORT

FEBRUARY, 1974

FRESNO COUNTY

PUBLIC HEALTH, MENTAL HEALTH

A CONSOLIDATION REPORT

Public health admin -- CA --
Fresno Co.

Mental health serv. -- CA --
Fresno Co. -- Admin.

PREPARED BY
THE OFFICE OF THE
COUNTY ADMINISTRATIVE OFFICER

FEBRUARY, 1974

THE COUNTY OF FRESNO 1856

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MEMORANDUM

March 4, 1974

To: Board of Supervisors

Subject: Departments of Public Health/Mental Health Consolidation Report

In July, 1973, this office initiated a study toward determining the feasibility of consolidating the Departments of Public Health and Mental Health. That study has now been completed and is attached for your review and consideration.

The report attempts to explain the need for changes in the organization and delivery of public health care services of the County; the requirements and present functions of the County's Public Health and Mental Health Departments; the changing health care scene; and a proposed consclidated organization.

The conclusion is, of course, that consolidation is not only feasible, but mandatory if we are to efficiently, effectively, and economically meet the needs of people. It calls not only for consolidation, but also, through a two-year phasing period, for decentralization, the establishment of health care centers, development of a team delivery system, and a greater effort toward preventive services. It also calls for close coordination and cooperation with those other agencies, both public and private, who are involved in the delivery of "human services".

It should be noted that the proposal was developed as a result of innumerable personal meetings and other contacts with nearly all of the employees of the two departments, as well as other department heads, State officials, and private organizations. The report has been reviewed by the Health Services Committee of the Fresno County Medical Society, which has endorsed the consolidation proposal. However, some Committee members expressed concern for greater involvement of the Valley Medical Center in the decentralized delivery of services. The report also concurs with the recommendations for consolidation of the 1973 Fresno County Grand Jury and the Fresno County Reorganization Advisory Committee.

On the basis of the proposals made in the report, it is recommended that your Board:

1. Adopt a resolution consolidating the Departments of Public Health and Mental Health into a single Department of Health.

2. Approve the concepts of health care delivery, as detailed in the attached report.

3. Instruct the County Administrative Officer, as soon as possible, to appoint a permanent Director of the Department of Health.

4. Instruct the County Administrative Officer to implement the findings which are called for in the report, reorganization of the department, certain classification changes, including reclassifying the existing Health Officer position to Assistant Director of Health, space analysis, and closer coordination with other County departments.

M. G. Wingett

M. G. WINGETT
County Administrative Officer

MGW:SDG:ld

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

CHAPTER I

COUNTY HEALTH REORGANIZATION: AN INTRODUCTION

In July of 1973, this office initiated a study toward the consolidation of the Departments of Public Health and Mental Health. That study was done in conjunction with your Board's appointment as Acting Director of Public Health, Dr. Trevor Glenn, the County's Mental Health Director. The results of that study support both the findings of the County Grand Jury and the Board's County Reorganization Committee that there should be a consolidation of the two departments. While this office is requesting your Board's support for the consolidation, it is also requesting that your Board consider some philosophical changes in regard to county organization and, specifically, to the future delivery of health care services. It is toward these ends that this report is being presented to you.

Program Integration to Meet the Needs of the People

Historically, counties of California have been a reasonably visible government. Initially, such visibility ranged from the only form of government in our early communities to the traditional arm of the state in administering welfare and collecting property taxes. However, as time passed and new programs, functions, and responsibilities have been mandated to County government on a fragmented and piecemeal basis, the organizational structure of the counties has changed drastically. As an example, and specifically for the purposes of this report, in examining the Health Care related departments (human services) of any county in California, you will be confronted with the necessity of trying to comprehend how those various organizational units interrelate and, more importantly, provide public services with some degree of mutual goals. It is doubtful if there is a county in the state where the organizational structure relates to services, where the diversity and number of departments does not result in total confusion to the public, or where the Board of Supervisors can fully understand and appreciate the complexities of the services. At the same time, those in administrative positions are frustrated with the difficulty of effectively coordinating health care services to accomplish the major goal: to meet the needs of people. The basic hierarchy of county government often creates artificial separation of services, multiple contacts by the public to accomplish a single purpose, confusion to the

public, and some unnecessary costs. Changes in philosophies, attitudes and acceptance will be necessary if local governments are going to be able to act in such a way that will promote fundamental changes in county government. The organizational structure of county health agencies must be more service-oriented. Separate departments need to be restructured with a view towards the integration of services that responds to predetermined goals. The public has the right and the responsibility to judge county government by accomplishments, which too frequently appear as successful efforts to prevent situations that would be adverse to county interests, rather than positive, aggressive programs that are convincing to the public and acceptable to the Board of Supervisors. One positive new approach means shedding some rather antiquated views of the interrelationship of county departments. Usually, the separate levels involved in any one program means unnecessary complexities in administration, excessive cost burdens without enhanced services, and the wasteful consumption of human energies in confrontations of internal conflicts. The time has come to look towards organization to be placed under one entity, performing one program rather than the involvement of multi-agencies with more limited authorities and, therefore, limited accountability for results. Now while that statement may be made for any number of departments, services and programs in the county, this report will deal specifically with one--Health Care Services (Human Services). The county of the 1970's must recognize that it can no longer afford, nor will the public tolerate, irrational separation of services to satisfy the existence of any public agency. If the county of tommorrow is identifying objectives and measuring the success or failures of achieving such objectives, there must be new concepts of evaluation. Too little attention has been given to evaluating the results of programs to determine where there should be changes instead of undisturbed continuation. It is hoped, in some small way, this report initiates the Fresno County's movement toward that goal.

CHAPTER II

THE FRESNO COUNTY HEALTH DEPARTMENT

INTRODUCTION

The Fresno County Health Department provides a wide range of services to the community, many of which are mandated by state law. However, the extent of many of these services is determined not by law but by the traditional commitment of the community.

California County Health Departments traditionally were the public agencies concerned with the fight against the spread of communicable diseases and against conditions leading to ill health. Over the years, their role has expanded through legislation and local necessity to cover health education, environmental health, nutrition, disaster services, occupational health, etc. generally covering those health aspects which can be described as preventive medicine. In summary, the Health Department's role is to help the community avoid ill health, be it caused by disease or the environment, and to minimize any disabilities resulting from illness once it is present.

LEGAL MANDATE

Public Health is essentially a county responsibility although the state sets overall standards of operation. There is tremendous variation in the degree, quality, and comprehensiveness of local public health programs offered by each county.

Chapter VIII, Part 2, Division 1 of the California Health and Safety Code contains operational standards which were adopted by the California Board of Public Health in 1947. They provide detailed analyses and descriptions of how programs should be established so as to qualify localities for state aid and local health administration.

Basic services required to be offered to the health jurisdiction which it serves are as follows:

a. Collection, tabulation and analysis of all public health statistics, including population data, natality, mortality, and morbidity records, as well as evaluation of service records.

b. Health education activities including, but not necessarily limited to staff education, training, consultation, community organization, public information and individual and group teaching. Such activities are planned and coordinated within the department and with the schools, public and voluntary agencies, professional societies, civic groups and individuals.

c. Communicable disease control including availability of adequate isolation facilities, the control of acute communicable diseases and the control of TB and VD, based on provision of diagnostic consultative services, epidemiologic investigation and appropriate preventive measures for the particular communicable disease hazards in the community.

d. Medical, nursing, educational, and other services to promote maternal and child health, planned to provide a comprehensive program to meet community needs in these fields.

e. Services in environmental health to include appropriate activities relating to water, food, air, waste, vectors, housing, bathing places, and safety.

f. Laboratory services provided by an approved public health laboratory which shall provide:

    1. Services necessary for the various programs of the health department, and

    2. Consultation and reference services to further the development of improved procedures and practices in laboratories employing such procedures related to the prevention and control of human disease.

g. Services in nutrition including appropriate activities in education and consultation for the promotion of positive health, the prevention of ill health, and the dietary control of disease.

h. Services in chronic disease which may include case findings, community education, consultation or rehabilitation for the prevention or mitigation of any chronic disease.

i. Services directed to the social factors affecting health and which may include community planning, counseling, consultation, education and special study.

j. Services in occupational health to promote the health of employed persons and healthful work environment including educational, consultative, and other activities appropriate to local needs.

k. Appropriate services in the field of family planning which may include:

1. Promotion of availability of program elements such as:

A. Assembling knowledge about family planning, attitudes, values, and information held by population groups.

B. Public and professional educational services about the health benefits of family planning and fertility control methods.

C. Professional services for sterility correction, fertility control, and genetic counseling for all segments of the population making available methods acceptable to families of any religious persuasion.

D. Evaluation of the adequacy of the community's family planning efforts.

2. Provision of program elements which are not otherwise likely to be made available including family planning services for those groups who cannot reasonably obtain them.

FRESNO COUNTY OPERATIONS

State law states what areas are under the jurisdiction of the health department and also states the minimum qualifications for key staff so that the department qualifies for state aid. It does not, however, state (with the exception of crippled children's services) how services should be provided or the extent to which services must be provided. As a result, there is no concrete legal service level mandate with which to compare. Consequently, Fresno County, as in most other counties, has a health department program that has evolved through a process whereby increases in service occur in response to various community needs, the concerns of the health officer, and decisions made by the Board of Supervisors.

The Health Department, in order to receive state funds, complies with the state standards which apply predominantly to the qualifications of the staff. The state also recommends certain ratios for key service staff to the total population.

At the present time, the Health Department is divided into several functional sections providing direct and indirect services. Those services may be summarized as follows:

Health Education

The division of Health Education assists in planning health programs for community groups and acts as a consultant for any community health problem. The division offers to the public a complete library of books, films, and resource information covering the spectrum of public health topics. In addition, a full selection of pamphlets and handouts are available.

Immunization Services

Immunizations are provided to protect the client from disease. To be effective, immunizations are required to be brought up to date periodically. Immunizations may be received for diptheria, tetanus, whooping cough, polio, measles and rubella. Immunizations are also provided for foreign travel.

Chest Clinic

This service finds, treats, and prevents the spread of tuberculosis. Services offered are tuberculosis skin tests, x-ray examination, other laboratory tests, when indicated, medical examination supervision and drugs for treatment.

Home Care Services

These services provide health and treatment in the home for persons with certain medical needs. A patient can receive help with personal care, injections, exercises, surgical dressing changes, speech problems, and many other needs.

Venereal Disease Clinic

This clinic provides medical help for persons who have venereal disease. Services offered include medical examination, laboratory tests and treatment.

Medical Night Clinic

This clinic provides care for common medical problems. A patient receives a medical examination, treatment, laboratory tests, when needed, health information, and information about other health and social resources.

Maternity Service

Early and regular maternity care during pregnancy contributes to better health for both mother and child. The expectant mother receives: periodical medical examinations during pregnancy, medical examinations after birth of child, information about pregnancy delivery, infant and child care, immunizations, if needed, help with diet and food budget, home visits by public health nurses, laboratory tests, when indicated.

Crippled Childrens Service

This service offers medical care to persons under 21 years who have certain physical conditions resulting from birth defects, disease, accidents or faulty development. Services provided are diagnosis, treatment and supervision, hospital care, surgical care, physical and occupational therapy, necessary corrective appliances.

Community Nursing Service

Public Health Nurses give part-time nursing care, instruction about care of the sick, and health guidance to persons of all ages in the home and schools and in health department clinics. Services are provided to the general public, physicians, hospitals and other agencies.

Environmental Health Services

This division promotes good public health practices through education, inspection, and enforcement of health regulations. The division services include: food, meat, and milk inspection, water supply inspection, housing inspection, inspection of hospitals and nursing and boarding homes, control of liquid and solid waste disposal, communicable disease control including rabies, vector control--insects and rodents, air pollution control, occupational health, consultation services, land use and development.

Family Planning Service

This service provides help with birth control methods, sterility problems, and genetic counseling. Patients will receive a medical examination, information about birth control methods, choice of available methods for birth control, laboratory tests, when needed, medical counseling for sterility and genetic problems, information about related health and social resources.

Well Child Conferences

Only well children (infant and pre-school) are seen in the well child conferences which provide the regular medical checkups that help keep children in good health. If children are sick, they should be seen by a physician, taken to a hospital, or to one of the health department medical night clinics. Services children will receive are regular medical examinations, immunization and tuberculin (skin) tests. Services the parent can receive are help with problems in feeding the child, understanding his behavior, growth and development, protecting the child from accidents, help in obtaining diognostic or treatment services, when needed.

Birth and Death Record Service

Certificates of births and deaths occurring in Fresno County within the last five years are kept on file at the Fresno County Public Health Department.

Nutrition Services

The County Public Health Nutrition program may be described as one through which adequate nutrition care is provided to groups and individuals for whom the County has health and welfare related responsibilities. In general, the program includes these activities: consultation, nutrition education, investigation, community planning and coordination, and promotion.

Laboratory Services

The Public Health laboratory provides services in bacteriology, mycology, parasitology, virology, serology, chemistry, and other related areas in support of the various activities of the health department and as an aid to local physicians. The division also provides consultation, technical training, and laboratory reference services to local laboratories upon request.

BUDGET REQUIREMENTS

The 1973-74 budget for the Fresno County Health Department is as follows:

Salaries & Employee Benefits	$2,417,867
Services & Supplies	1,376,046
Fixed Assets	49,881
Other Charges	83,298
Less Cost Applied	16,000
Total Budget	$3,911,092

Revenues to the department are listed below:

State of California

Crippled Childrens Services	$ 558,014
Health Administration	100,000
Air Pollution Control Grant	83,298
Home Health Agency	4,500
Total State Revenue	$ 745,812

Federal

Home Health Agency	$ 11,000
Partnership in Health (314.D)	73,474
Maternal & Child Health	15,423
Air Pollution Control	80,000
Total Federal Revenue	$ 179,897

Local

Crippled Children	$ 50,000
Milk Inspection	65,000
Lab fees	45,000
Permit fees	1,140
Home Health Agency	27,500
Westside Night Clinics	1,500
Vital Statistics	30,000
Home Health	5,000
Physical Exam	1,150
Demolition	5,000
Total Local Revenue	$ 231,290
Total Revenue	$1,156,999
Net County Cost to General Fund	$2,754,093

Personnel requirements of the department are broken down by major function:

Administration	24
Environmental Health	64
Nursing Services	72
Laboratory	20
Crippled Children	18
Clinic Services	19
Total Personnel	217

CHAPTER III

FRESNO COUNTY DEPARTMENT OF MENTAL HEALTH

INTRODUCTION

A new role for the county is currently being defined in light of the Community Mental Health Services Act, Division V (which includes both the Lanterman-Petris-Short Act and the Short-Doyle Act). It is the intent of the state that mental health is to be a locally based service. This is reflected in the fact the state is involved in the phased closing of its regional mental health hospital facilities.

LEGAL MANDATE

The Community Mental Health Services Act, which is in Division V of the Welfare and Institutions Code, became law in July of 1969. The Act represented the effort by the State of California to develop a comprehensive state-wide system of care, and perhaps more importantly, a system of care which integrates mental health services as provided by local governments, state hospitals, and private agencies. The major thrust of the Act is that the county should have a greater role in assuring the provision of mental health services. The underlying assumption is that the available dollars for such services should "go with the patient" to the local facilities.

The present Community Mental Health Services Act is a composite of two previous acts: the Lanterman-Petris-Short Act and the revised version of the Short-Doyle Act of 1957. The significant features of each are as follows:

The Short-Doyle Act

-- Providing mental health service is mandatory rather than elective in each county with a population of 100,000 or more.

-- The county is designated as the local unit of government to provide the mental health services. (The two city Short-Doyle programs existing in 1969 were included in county Short-Doyle plans.)

-- The county must develop and adopt a mental health program annually, specifying services to be provided in county facilities and, by contract, in state hospitals and through private agencies.

- The State Department of Health receives a single appropriation for services for the mentally disordered. The Director of the State Department of Health allocates the funds available to the counties on the basis of approved county Short-Doyle plans.

-- The reimbursement formula for local mental health services is 90 percent state reimbursement of net costs and 10 percent local expenditure.

-- There are ten services for which a county Short-Doyle plan receives reimbursement: inpatient services, outpatient services, partial hospitalization, emergency services, consultation and education services, diagnostic services, rehabilitation services, precare and aftercare services, training, and research and evaluation.

-- Except for those services provided for judicially committed patients, services in community and state facilities will be provided under a single system of care under the general supervision of the local community mental health director.

-- A 15-member Citizens Advisory Council advises and assists the Director of the State Department of Health on the implementation of the provisions of the Community Mental Health Services Law.

-- Short-Doyle programs have local mental health advisory boards consisting of 14 members.

The Lanterman-Petris-Short Act

-- Mentally disordered persons, chronic alcoholics, inebriates, and users of narcotics and dangerous drugs may be furnished services under the act.

-- Individuals who are gravely disabled or a danger to themselves or to others, but who are unable or unwilling to voluntarily accept public or private help, may be involuntarily detained for treatment in county designated facilities. Involuntary treatment must be in accordance with specified time limits and procedures.

-- Every person retains the right to judicial review any time he is held involuntarily.

-- Certain legal and civil rights are guaranteed to all patients. These rights are prominently posted in both English and Spanish in each facility and are brought to the attention of the patient when he enters the facility.

-- A conservatorship procedure is specified for patients who are "gravely disabled" as a result of a mental disorder or impairment by chronic alcoholism.

FRESNO COUNTY OPERATIONS

At the present time, the Mental Health Department is divided into several functional divisions providing both direct and indirect services. Those services may be summarized as follows:

Crisis Intake Service

Crisis Intake is the "front door" for all adult services at the central location. No appointment is necessary. The hours are from 8 a.m. to 11 p.m. Monday thru Friday and 1 p.m. to 9 p.m. weekends and holidays. Anyone wishing admission to any of the services is seen by the intake worker and admitted to the appropriate service if treatment is needed. Crisis Intake Service provides short-term treatment for patients to help resolve immediate problems that present themselves as a life crisis. If a patient needs long-term therapy they are referred elsewhere in the department.

Adult Outpatient Service

Adult Outpatient is for adults 18 years of age or over. Individual therapy, group therapy, conjoint therapy and medication is provided. New patients are referred from Crisis Intake. Appointments are usually weekly and last approximately one hour.

Partial Hospitalization (Adult Day Treatment)

This service provides treatment for people who are able to care for themselves overnight and on weekends who do not need 24-hour care, but are in need of more intensive care than outpatient services provide. Individual therapy, group therapy, family therapy, occupational therapy, recreational therapy, social rehabilitation services, and prescribing of medication are available in day treatment.

Narcotic Abuse Treatment Program

The major comprehensive goal of the Narcotic Abuse program is to aid the patients in the alterations of their life styles with the ultimate aim of eliminating all dependencies on addictive substances.

Rehabilitation Service

The Rehabilitation Service consists of the following components:

-- Care Facility Consultation Team - this team consults with the staff of nursing care facilities in the

community to help them develop treatment and activity programs for their clients and potential clients for the department.

-- Rehabilitation Center - this program provides a basic program for improvement in activities of daily living, socialization, interpersonal relationships, and preliminary productive pursuits such as in-house work, etc.

-- Prevocational Center - this program prepares the client for maximum productivity, which may be volunteer work, sheltered workshop, or employment through a series of prevocational training steps from minimal demand activities to skilled labor.

-- Socialization Program - this program crosses the other services and provides a range of structured social and recreational activities and unstructured opportunities, depending on the client's need.

-- ARCO Training - the Service Station Attendant Training Program is our only actual job training program at this time. It serves as a prevocational experience with close supervision, has a sheltered workshop type setting for some clients and some clients have progressed to employment with the program.

-- Volunteer Placement - as an experience of low pressure work, this program may be a maximum level of attainment for some clients or may be a preliminary step for employment for others.

Advocare

The aftercare and advocacy program is designed to help people living in the community and provide protective services. One aim is to assist people to regain the ability to deal with their daily lives. It offers services in learning to use community resources and is aimed toward establishment and maintenance of self-help. Patients who participate may also be enrolled in one of the other treatment services.

Inpatient

The Inpatient Service is used as a last resort. It provides 24-hour care for patients who are currently unable to adapt in the community, who are too disruptive or uncomfortable, or who are a danger to themselves, others and/or are greatly disabled.

Youth Outpatient Service

This service offers a walk-in clinic which serves people under the age of 18 and their families. Group therapy, individual therapy, family therapy, and medication is provided. There are groups for all ages, children and adolescents with collaborative groups for their parents, specialized groups such as marital counseling groups and groups for young mothers are also available.

Adolescent Day Treatment

This service serves adolescents from approximately 11 to 18 years of age who do not require inpatient treatment, but who require more extensive services than outpatient treatment provides. Educational and occupational therapy, recreational therapy, vocational counseling, group and individual psychotherapy, medication, parent counseling and individual and group family counseling are offered. A behavioral modification program is used in the adolescent day treatment program.

Pre-Adolescent Day Treatment

This service serves pre-adolescents from the ages of 8 to 12 years of age, who do not require inpatient treatment, but who require more extensive services than outpatient provides. It is provided in school facilities in cooperation with the public school system.

Group Homes and Residential Treatment

At the present time, one psychiatric social worker is assigned to work with the two group homes in Fresno County: Harambee House and Villa Carmel. A residential treatment program is being planned.

Outreach Services

This service provides outreach services in various parts of the county. These include crisis intake and outpatient services for both children and adults. At present, the outreach services are divided into two teams: the East team goes to Sanger, Selma, Orange Cove and Del Rey; the West team goes to Coalinga, Firebaugh, Mendota and West Fresno. These teams are based at the central location at the present time but plans are that each location would have a resident employee who would be available for crisis intake service.

Consultation, Education and Information Programs

This service offers consultative programs to various agencies within the county which are concerned with prevention of

emotional or psychiatric disability and promotion of mental health. Some of these include Valley Medical Center, Welfare Department, city and county schools, Juvenile Hall, Probation, Fresno Police, Sheriff's Department, and others.

General Services

General Services is responsible for providing and/or coordinating with other county departments the following activities: personnel, supply, contract negotiations, housekeeping, medical records, and clerical program support.

Fiscal Services

Fiscal Services is responsible for providing and coordinating budgeting, accounting, patient eligibility, billing and collections, and electronic data processing activities for the department.

Evaluative Services

Evaluative Services operates under the philosophy that the staff which provide the treatment should also evaluate its effectiveness. Evaluation, when done by the staff, provides them with feedback as to how well they are doing and allows them to adjust accordingly. Evaluation in this framework naturally feeds into and grows out of program planning. Evaluative Services perceives program evaluation in the following way:

1. As an integral and ongoing part of the planning process.

2. As the method of determining whether predetermined program objectives have been attained.

3. As a process that obtains its subject matter and direction from the staff directly involved in the service being evaluated.

4. As a feedback mechanism to planners and implementors of programs and services.

5. As having as its ultimate goal the continuous improvement and maximum utilization of available resources.

Training and Staff Development

The inservice training and staff development program is responsible for two aspects of training in the department. One is related to the staff of the Department of Mental Health and the second is related to the students from various educational institutions who receive their clinical training in the department.

Public Relations, Information, Legal Interpretation

Public relations for the department are coordinated through the Director's Office and is responsible for: providing the public with general and specific information about the department; receptionist services to the Crisis Service and initiating the intake procedure for patients applying for help; consultation to all areas of the department regarding interpretation of the mental health laws; coordinates and authorizes release of patient information; liaison to the legislative offices and to the Mental Health Advisory Board.

Substance Abuse Program

The Director of the department is the designated county officer responsible for developing a coordinated county-wide community substance abuse control plan. The department employs a Drug Abuse and Alcohol Coordinator and staff which acts as liaison and coordinator between all public and private programs related toward dealing with substance abuse, which includes drugs and alcohol. He is available for speaking to the public, to develop volunteer training programs and can provide information about substance abuse in the county. He is staff to both the Technical Advisory Committee on Drug Abuse appointed by the Board of Supervisors, and the current Alcohol Advisory Council.

BUDGET REQUIREMENTS

The 1973-74 budget for the Fresno County Mental Health Department is as follows:

Salaries & Employee Benefits	$2,604,775
Services & Supplies	3,586,289
Other Charges	35,295
Fixed Assets	54,763
Total Budget	$6,281,122
Misc. County Costs	473,341
Total Budget Expenditures	$6,754,463

Revenues to the department are listed below:

State of California

714 Drug Funds	$ 317,424
Methadone Funds	178,387
SB 204 Alcohol Start-up Funding	44,219
Short-Doyle Alcohol Funds	45,000
Medi-Cal	699,238
Short-Doyle Reimbursement	3,651,459
Total State Revenue	$4,935,727

Federal

Hughes Alcohol	$ 56,030
Social Rehab. Services	355,442
Medi-Cal	699,238
Total Federal Revenue	$1,110,710

Local

Private Patient Fees	$ 80,402
Private Insurance	104,638
Consultation Fees & Misc.	9,704
County Methadone Funding	107,564
Total Local Revenue	$ 302,308
Total Revenue	$6,348,745
Net County Cost to General Fund	$ 405,718 *

*Does not include Methadone contributions.

Personnel requirements of the department are broken down by major function:

Administration	60
Crisis	75
Youth Services	50
Continuing Care	95
Indirect Services & Outreach	22
Substance Abuse	5
Total Personnel	307

CHAPTER IV

HEALTH CARE

WHAT IS HEALTH?

The traditional definition of health has been "the absence of disease", however, in today's changing times the more acceptable definition is one which is found in the Constitution of the World Health Organization which states "health is the state of complete physical, mental and social well-being".

THE CHANGING HEALTH CARE SCENE

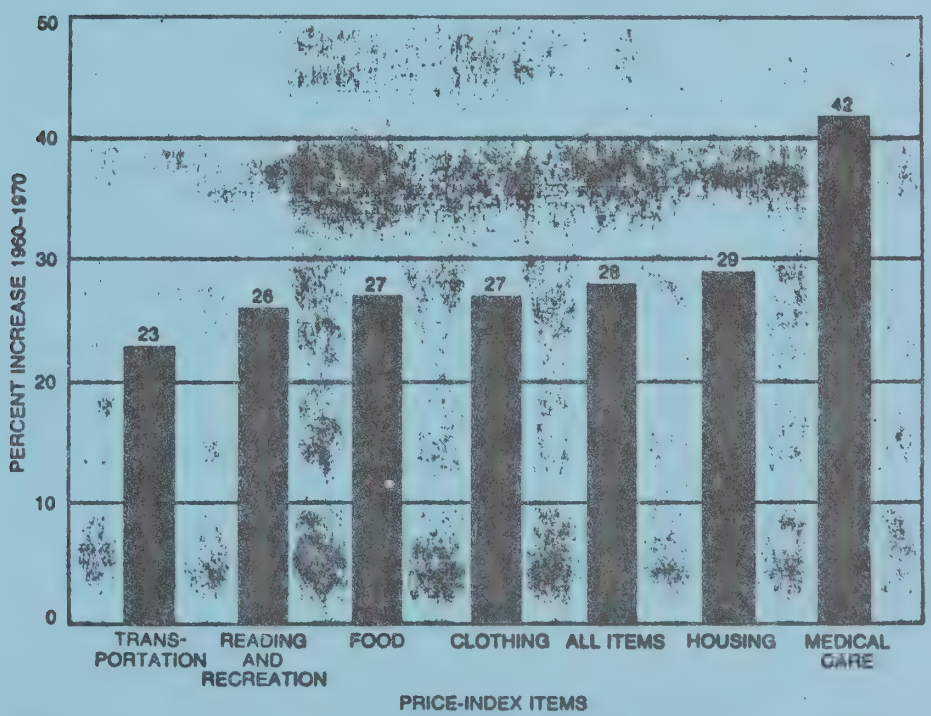
It might be best to begin this section quoting from page 227 of Durbin and Springall's Organization and Administration of Health Care, section entitled "Postscript":

> "As an industry, american health care is in its infancy. Like its big brothers in the profit sector, it will grow hard and fast. Because it is an industry, it must establish a committed objective and move toward it with objective intelligence. Unlike the profit sector, its impetus will be social pressure for change.
>
> The american public is demanding change in health care. The nature, means, and direction of that change is still very general. But simple and cursory scanning of "the handwriting on the wall" can reach no other conclusion than that of inevitable change.
>
> Change requires cause, hope and direction. Resistance to change indicates that the greatest cause, hope, and direction lies in the status quo. Social change is largely evolutionary because a common cause sufficient to spawn revolutionary action does not often occur among the masses. In administrative organizations, however, specific boundaries are identifiable and organizational environments may be deliberately generated and worked with. Revolutionary change may be created and molded in predetermined direction.
>
> Voluntary health care institutions and practitioners and the system that they constitute will be brought to response by the public and their governments. The question begging for an answer is: "Who will take the initiative and who will call the shots?""

It is interesting to note that while health care as an industry is referred to being in its infancy, it is the second largest industry in this country--only the construction industry being larger. The change in health care being demanded today is coming from two directions. First, due to the increased cost of medical care (see Figure 1), combined with an increased appreciation of health by the consumer and an awareness of the "right" to adequate health care for all in a health care delivery system. Second, pressure is being exerted by those within the field (physicians, nurses, technicians, administrators) who recognize that what we have today is a "non-system".

The critical issues of health today are not technological, nor are they financial, but rather are organizational. The major issues facing our health care system today cannot be solved without fundamental changes in the structure of health services, i.e. their organization and the way they are delivered, as well as their financing.

Figure 1



DRAMATIC RISE in recent years in the cost of supporting a health-care establishment in an industrialized society is put into perspective in this chart, which compares the percent increase in the cost of medical care in the U.S. with other major components in the consumer price index for the decade 1960–1970. The chart is adapted from one in a recently published book, *Dynamics of Health and Disease*, by Carter L. Marshall and David Pearson.

*Source: White, Kerr L. "Life and Death In Medicine", Scientific American, September 1973, p. 32

Fresno County, like most of its sister counties around the state presently provides a fragmented, proliferated and duplicated "non-system" of health care. County departments involved in this non-system include the County Health Department, the County Mental Health Department, Valley Medical Center, County Welfare Department, County Schools, and Probation Department.

Eli Ginzberg, Professor of Economics at Columbia University and a past member of the National Advisory Mental Health Council said:

> "Health care involves much more than the provision of adequate medical care, though medical care obviously has an important part to play in the establishment and maintenance of effective health. It is in error to think of health as an entity separate and distinct from the other essential determinants of life--food, housing, education, work and life style. Health care is interwoven into the environmental and social fabric of society, therefore, unless attention is given to these factors, an improved health care delivery system will have little impact on the quality of health care."

Aside from the inevitability of change, the total health care field is faced with: increasing knowledge, increasing specialization, increasing complexity, increasing demand for service, and increasing institutionalization. All this leads to more technical, impersonal, and mechanized care. In order to take advantage of the knowledge and technology and to be able to cope with the demands, shortage of personnel and costs, some kind of organization must be created to turn the "non-system" into a "system" or interrelated network of services where the consumer does not have to stand outside the system and guess at which point he should enter. The consumer must be educated to the system, know his entry point and proceed between services as the health professional sees fit, from the least expensive necessary services to, if needed, the most intensive level of service.

Mental Health programming in California has stressed an organized coordinated network of services decreasing the use of hospitals, and the involvement of citizens in planning of coordinated services. This system has considered that cost has to be balanced with quality of service, acceptance by the consumer, and satisfaction to the provider.

The History of Medical Care

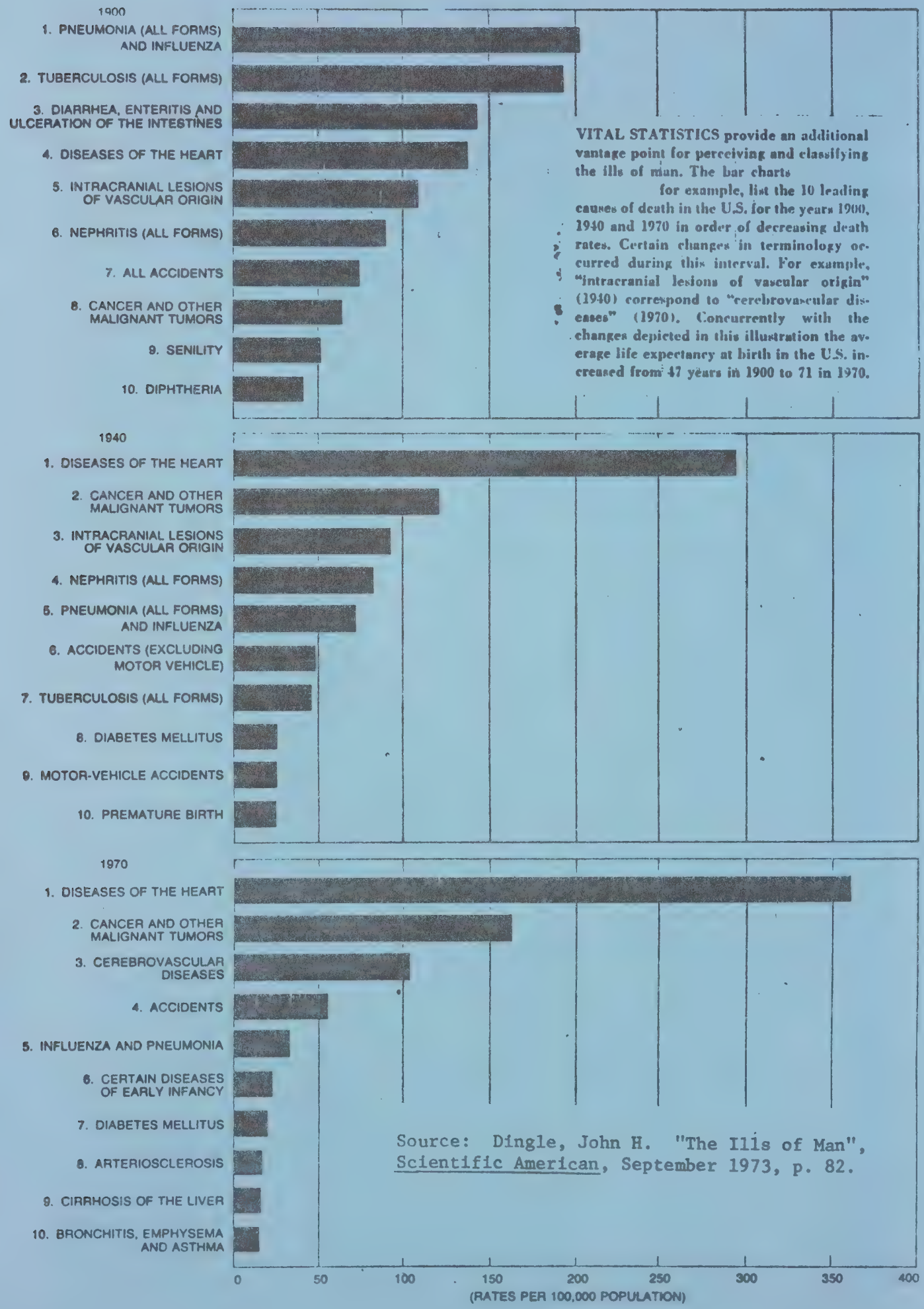
The science and technology of medicine has advanced enormously in the past 50 years and has necessarily resulted in increasing specialization. At the same time, however, there has been a

shif in the health goals of the public leading to disharmony between the needs and desires of society and the providers who serve them. The goals of most health professionals and the public previously have been defined in terms of diseases to be treated, eliminated and controlled and in the delivery of medical care, as opposed to health maintenance. The pursuit of technology over the past 50 years promised an ever increasing health and life span bringing the tools of technology to bear on the area of eliminating pathology (see Figure 2). For a long time, this seemed to work. People seemed to live longer, there was less illness and less distress. The pursuit of technology thus became the dominant feature of the American health care system. We recognize today that in such pursuit many of the concepts of health maintenance had to be abandoned or else given low priority, and the recognition of social well being as an important ingredient of health care was lost. We began to focus more and more on very specialized treatment for very complicated disease and "downgraded" preventive maintenance and routine care.

Today, however, the changed goal of the public is to maintain the greatest level of health attainable. The bulk of the health professional's current training has been treatment of symptoms and illness. Medical science must now begin to come away from producing hospital-based specialists to meet the needs of the hospitalized patients. This prior emphasis is quite different than meeting the health manpower needs of the community as a whole; burgeoning technology has resulted in specialization and the development of more complex, expensive resources in institutions. This bears little resemblance to the massive general health service needs of the population.

Specialization in medicine has increased since 1910 and the Flexner Report, which related to the quality of medical education. This has coincided with technical advances. General practitioners have decreased from 85% of physician manpower to 20%. Consumers can't find a single entry point into the system. Specialization has discouraged organization of health care which is fragmented and costly. A fragmented system cannot be held accountable--an organized system must be managed. Hospital services are indispensable components of health care but do not have the ability to improve the structure of the total health system since they deal only with illness. When hospitals are involved in the care of ambulatory patients, it is almost always to support one of their central functions, either inpatient care or the training of medical specialists. The former is for post-hospital follow-up, the latter for clinics and training purposes. More recently, hospitals have become involved in ambulatory care through emergency rooms because of the failure of medical care outside the hospitals to provide same. Consumers needing primary care now turn to

Figure 2

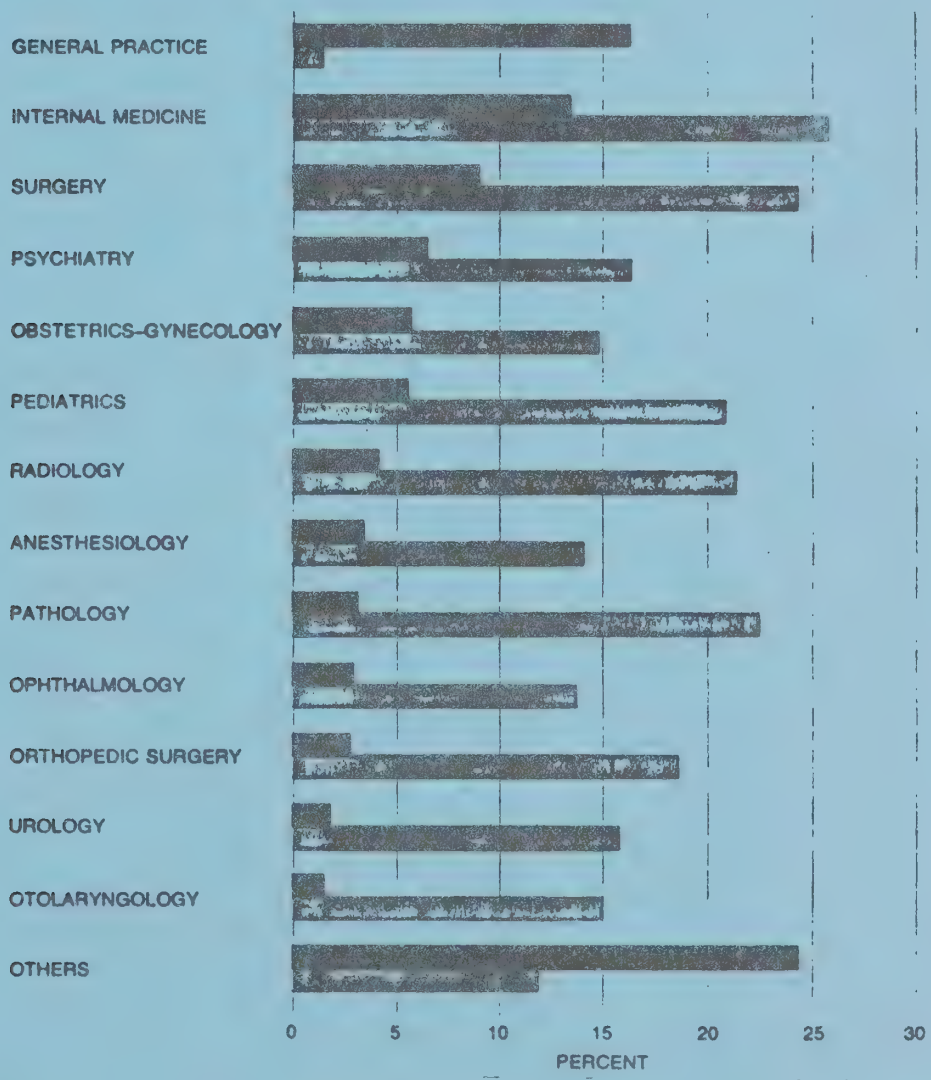


VITAL STATISTICS provide an additional vantage point for perceiving and classifying the ills of man. The bar charts for example, list the 10 leading causes of death in the U.S. for the years 1900, 1940 and 1970 in order of decreasing death rates. Certain changes in terminology occurred during this interval. For example, "intracranial lesions of vascular origin" (1940) correspond to "cerebrovascular diseases" (1970). Concurrently with the changes depicted in this illustration the average life expectancy at birth in the U.S. increased from 47 years in 1900 to 71 in 1970.

Source: Dingle, John H. "The Ills of Man", Scientific American, September 1973, p. 82.

emergency rooms because it is not available elsewhere. The current health "non-care system" also lacks continuity of care. Continued insurance coverage of the current care system intensifies the problem as it increases purchasing power of the consumer for episodic illness without doing anything to provide comprehensive health maintenance. The problem lies in the structure of care and the payment mechanism which perpetuates the most expensive type of care--specialized hospital care. The system must now be placed in balance.

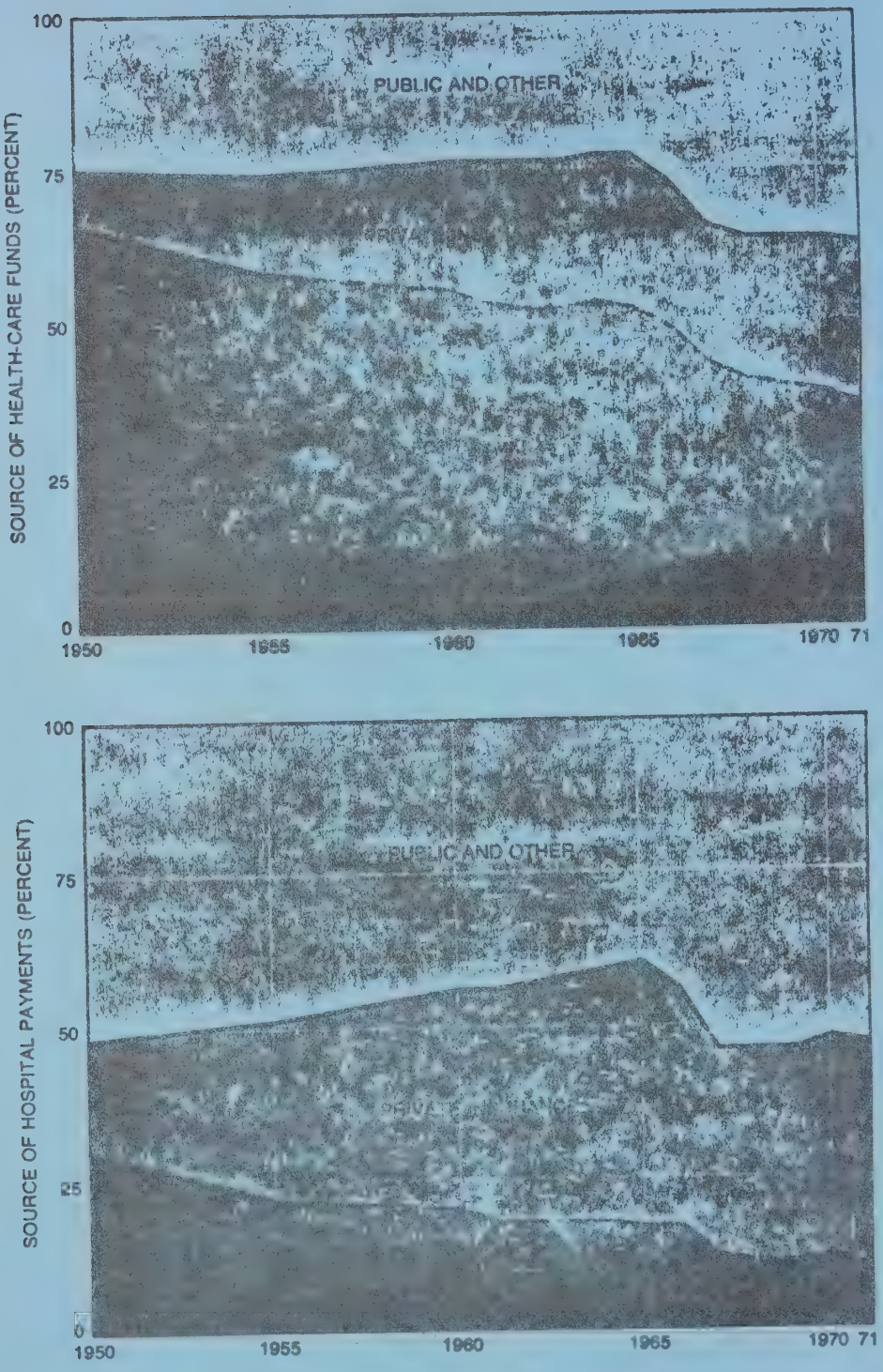
Figure 3



UNEVEN REPLACEMENT OF SPECIALISTS is suggested by a comparison of the percent of all physicians in each field (upper bar) with the percent of each field represented by house officers (lower bar), meaning interns and residents. In other words, general practitioners are not replacing themselves, whereas most other medical specialists are being replaced in excess.

Source: Ebert, Robert H. "The Medical School", Scientific American, Sept. 1973, p. 141.

Figure 4



STEADY DROP IN OUT-OF-POCKET, OR DIRECT, PAYMENTS has been the outstanding feature of the way American families met their medical bills. Whereas two-thirds of all health-care expenditures were paid out of pocket in 1950, only a little more than a third are paid that way today (*top*). For hospital-care costs the fraction paid directly by the consumer was lower to begin with and has dropped even faster: from 30 percent to 10 (*bottom*).

Source: Feldstein, Martin S. "The Medical Economy, Scientific American, September 1973, p. 154

The effect of Medicare and Medi-Cal

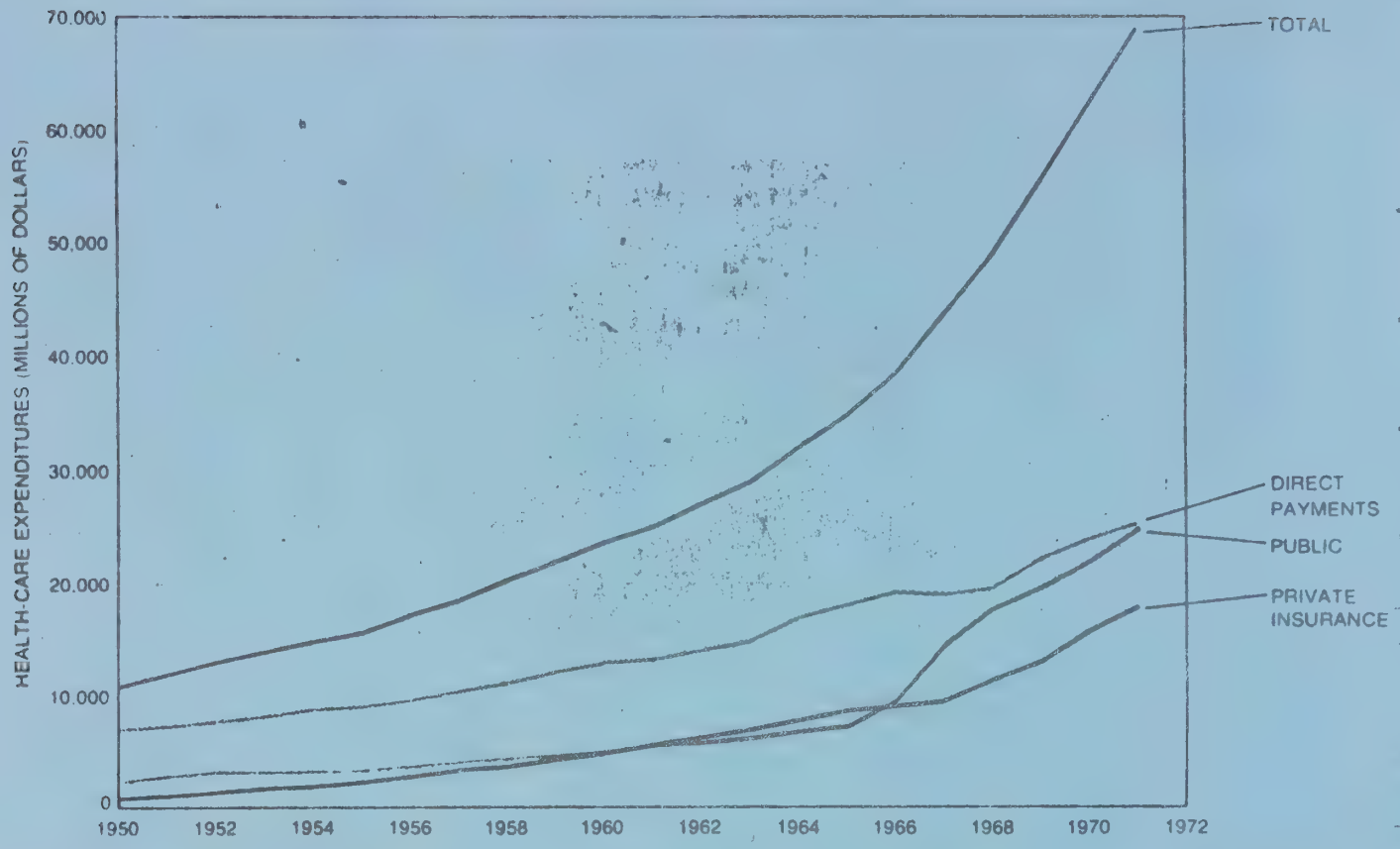
Medicare and Medi-Cal have had no effect on the "organization" of the care system. Through their reimbursement mechanism they have aggravated the manpower problem and placed costs and effectiveness of service in conflict. Likewise, national health insurance will not assure the medical care needed. It will only intensify the problem unless there is a restructuring of the care system itself. The demand for more care with the current physician manpower problem will only inflate unit costs. To overcome this problem, there must be an increase of primary care personnel as "gatekeepers" to specialists and hospital care. This less costly ambulatory care must be substituted when possible as an alternative to hospital care. Both public health and mental health have been oriented in this direction for some time. The persistence of preventable illness in medicine today reflects the lack of emphasis and effectively organized services to take the needed preventive measures to prevent disease.

Medicare and Medicaid are mechanisms of reimbursement or financing of medical care introduced in the mid-'60s. It has been since their inception that costs of medical care have risen rapidly and faster than the consumer price index. This appears to be for at least two reasons. First, they enable medical care to reach more people increasing the total cost of health care in proportion to the total cost of other consumer items. Second, their reimbursement focused on services provided in institutions where costs are supposedly more predictable and controllable. Because of this and the technological emphasis of medical education, there was more emphasis on hospital-type specialist care rather than the general ambulatory outpatient-type care. In addition, because these two reimbursement methods gave consumers more purchasing power, this placed more demands on the medical manpower available, which was already overburdened. Economically, this has driven up the unit cost of services,particularly those of the hospital type.

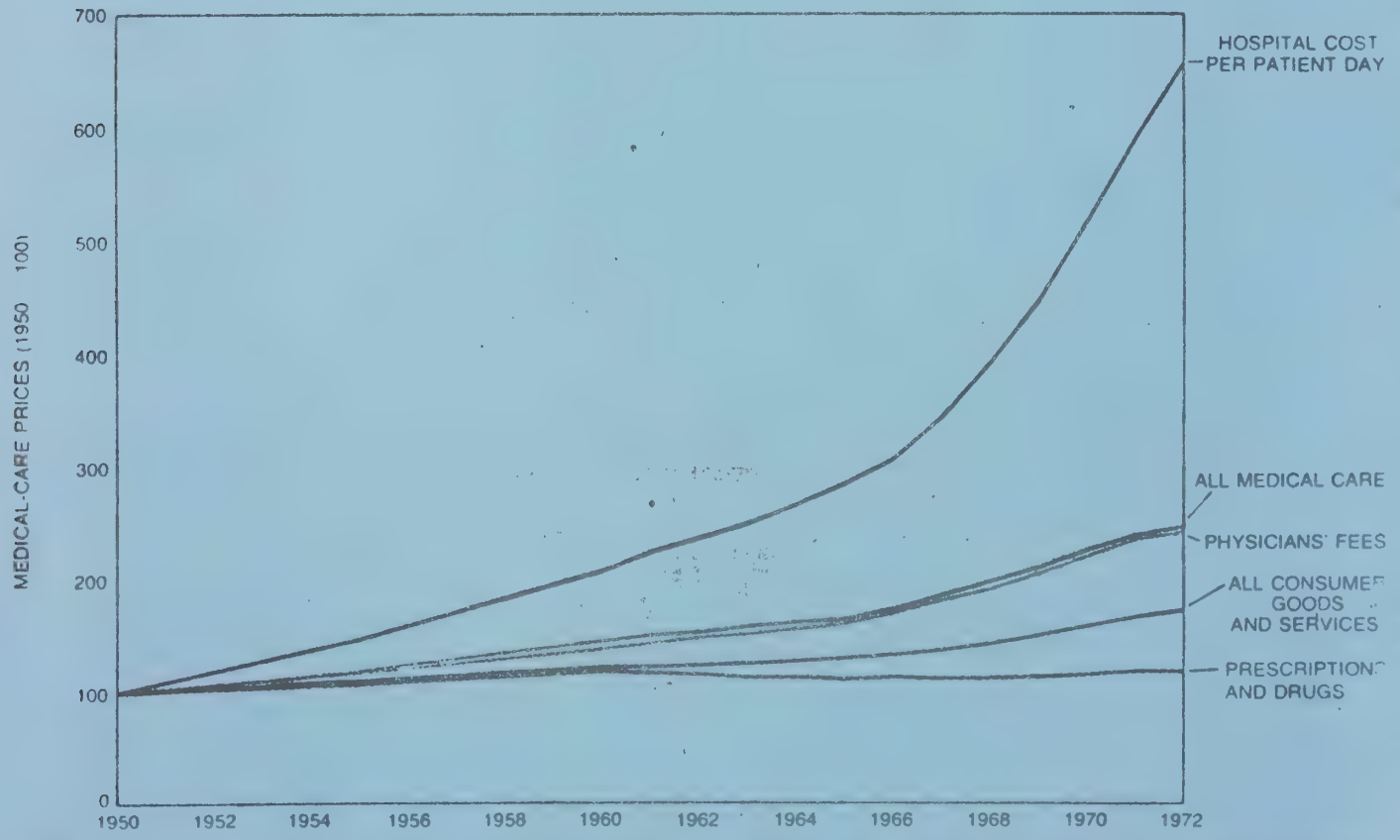
The Direction of Health Care Today

Organized medicine, organized institutions, voluntary agencies, and government for too long have each gone their own separate way with their own special interests. On the other hand, health maintenance organizations which emphasize a different organization of health care delivery bring the insurance industry, physicians, and the consumer together in new role relationships. This concept forces different special interest groups into new perspectives with each other. For example, an examination of health maintenance organizations shows that a integrated health care delivery system is possible with lower costs; and those which have mental health benefits and home health services

Figure 5



PAYMENTS FOR HEALTH CARE come from three main sources: from public funds, from private insurance benefits and in the form of direct payments by the consumer. Between 1950 and 1971 public expenditures for health increased tenfold (to $24.9 billion), private insurance benefits increased eighteenfold (to $17.9 billion) and direct payments about three-and-a-half-fold (to $25.2 billion).



COST OF HOSPITAL CARE has risen dramatically since 1950, far outstripping the rise in physicians' fees. As a result the overall cost of medical care has gone up faster than the average of all goods and services in the consumer price index. The indexes are adjusted to make 1950 equal to 100. Prescriptions and drugs have risen the least of all health-care costs: from 100 to 119. The cost of over-the-counter drugs actually fell in the years between 1950 and 1972, but the drop was more than offset by the doubling of prescription cost.

Ibid, p. 152.

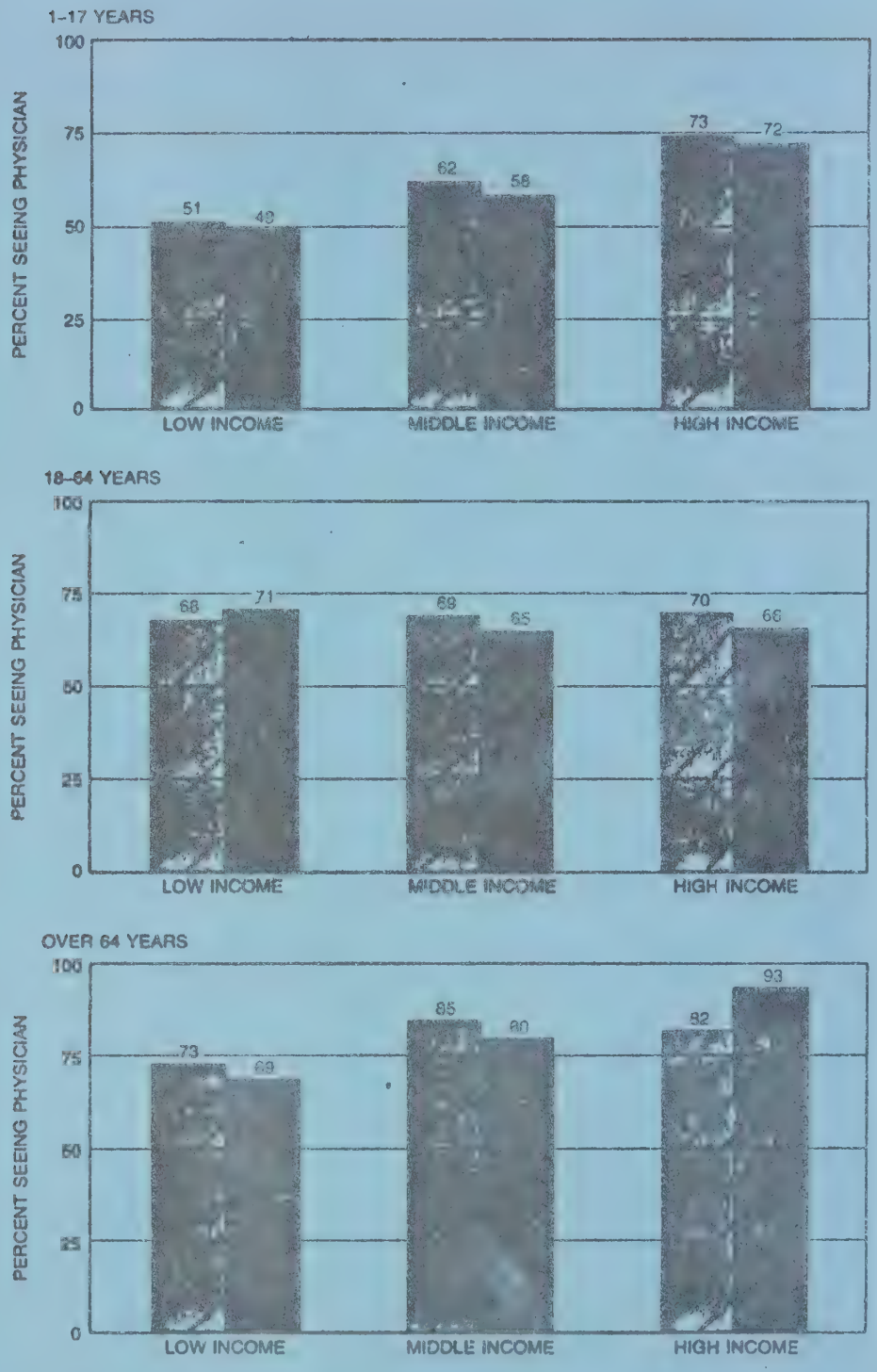
incorporated are showing themselves to lower the costs of other medical services between 15-30%. That is, those plans that use these services as "gatekeeping" or screening, rather than hospitalization are decreasing the number of hospital days utilized. In this way, there is integration and appropriate use of all service elements. Mental health and public health can offer this "gatekeeping" function to the rest of health care today. The general direction, then, that health care is taking today is: toward organized systems of care--away from fragmented services; toward multi-disciplinary approaches--away from over-reliance on physicians; toward comprehensiveness--away from limited services; toward preventive care and health maintenance--away from delayed treatment of illness; toward encouraging community services--away from incentives to hospitalization; toward encouragement of linkages with other human service systems--away from exclusive emphasis of health services; toward public consumer responsiveness and accountability--away from primary focus on health providers and their payors; toward expanding availability and accessibility of services--away from barriers to services.

Life Style and Illness

In reorganizing health care, we must make accomodations for the various life styles of patients, particularly the poor. One's life style affects his attitude toward illness and sickness. There is considerable evidence that socio-economic factors influence the utilization of medical care and receptivity to preventive health practices. Anselm L. Strauss in "Medical Ghettos", Transaction, 6:8 May 1967 wrote:

> "The reason the medical systems have not reached the poor is because they were never designed to do so. The way the poor think and respond, the way they live and operate has hardly ever (if ever) been considered in scheduling, paperwork, organization, and mores of clinics, hospitals, and doctor's offices. The life styles of the poor are very different; they must be specifically taken into account. Professionals have not been trained, and are not now being trained in the special skills and procedures necessary to do this. These faults result in a vicious cycle which drives the poor away from the medical care they need. Major reforms in medical organizations must come or the current great inequities will continue and perhaps grow. These recommendations are built directly upon aspects of the life styles of the poor. They do not necessarily require new money or resources. They do require rearrangement, reorganization, reallocation--the kinds of change and reform which are often much harder to attain than new funds or facilities."

Figure 6.



MORE THAN HALF OF ALL AMERICANS SEE A PHYSICIAN at least once a year, except for the children of low-income families who live in the central city. Even in that age group 49 percent see a physician once a year (grey bar at extreme upper left). The cross-hatched bars represent all individuals; the gray bars represent central-city residents. More of the high-income elderly in the central city visit doctors than members of any other group do.

Ibid, p. 156.

Designing a new and effective health care delivery system will be inadequate if socio-environmental factors are not given proper consideration. What purpose is there in providing adequate health care if the problems of poor housing, inadequate diet, population explosion, poor education, lack of work, lack of income, lack of social acceptance are left unsolved. These factors influence the total health picture of a society.

The life style of the poor not only hinders their participation in the mainstream of society, but often keeps them from receiving adequate health care in the present system. The complexities involved in the utilization of health care resources, attitudes, circumstances, sensitivity, and feelings of isolation and lack of acceptance are pertinent factors. A profile of the indigent shows that they have little experience with organizations and are insecure in the present middle class health system. The poor do not know how to "beat the system", to attract attention in the health environment, and many times do not understand or receive explanations on health care procedures because of faulty communication with health workers who have little comprehension of the patient's environment. Health professionals tend to be impersonal and abstract creating further gap. Often the poor do not take advantage of available facilities because they do not want to leave their neighborhood for care and usually the centralized hospitals and clinics are some distance away. The cost of transportation becomes a major obstacle. The poor often do not seek health care unless their symptoms are advanced, preferring to live with illness rather than use up their limited financial resources. They are anxious, sensitive, insecure and have little self esteem.

Conclusion

In summary, it appears that to become more efficient and effective we must move away from easily identifiable physical structures or institutions, traditional medical programs with traditional professional staffing and toward an overlapping with other human services. We would hope that the changing health care scene in Fresno County would hold the following:

1. That an integrated, coordinated health care delivery system is established to provide needed services to the public.

2. That consolidation of health care related agencies is accomplished to establish an organizational structure that relates to services.

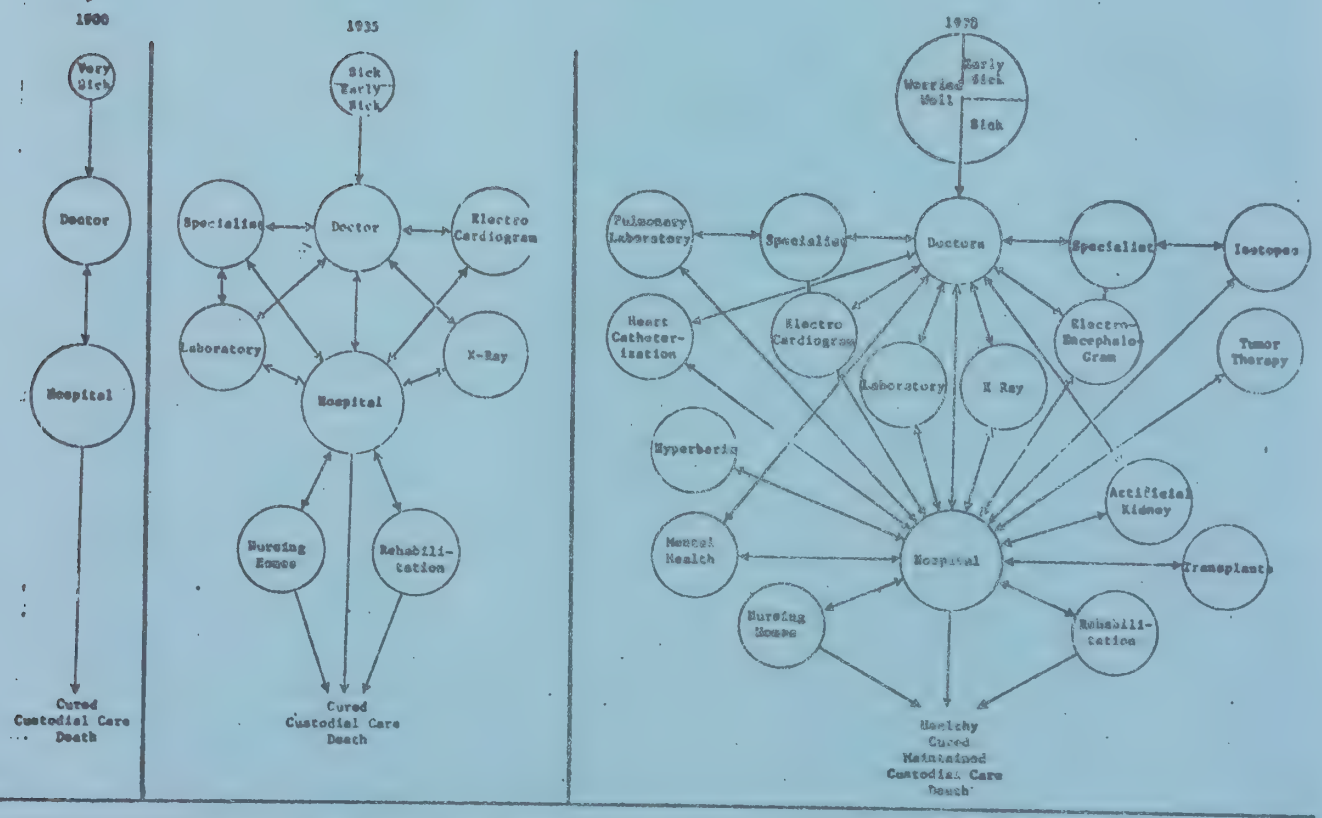
3. That the health care delivery system be balanced between prevention and treatment in order to bring about a state of complete physical, mental and social well being.

4 That decentralization of services be brought about to bring the service into the community where it can be more effectively delivered.

5. That the system be delivered by a multi-disciplinary health care team utilizing all providers of services in more appropriate roles.

If society has health problems, to whom should it turn if not to its health care establishment. In former times, an artificial dichotomy, professionally conceived, institutionalized, and perpetuated existed between "private medicine" and "public health". No longer does it appear sensible to separate preventive care from curative and restorative care or the public's health from the individual's health. These are attitudinal, professional, and institutional anachronisms for which there is no basis in contemporary knowledge or need.

Figure 7



MEDICAL CARE has become more complex in this century and as it has become more effective the entry mix of people has changed significantly. Yet the entry point is still the doctor's appointment. Before 1900 (left) medicine had little to offer and only sick people entered medical care. By 1935, as medicine began to have more to offer and as insurance plans appeared, some "early sick" people were entering the system (middle). Since World War II medical technology has proliferated, as indicated by the partial display of treatment components (right), and well people enter, largely because of prepayment, insurance plans, Medicare and Medicaid.

Source: Garfield, Sidney R., "The Delivery of Medical Care", Scientific American, April 1970, Vol. 222, No. 4, p. 20 & 21.

CHAPTER V

RESTRUCTURING THE COUNTY'S HEALTH CARE DELIVERY SYSTEM

Fresno County Government alone cannot resolve the problem of health care for the total population of the county. It can, however, establish the structure, philosophy, and policies which will set an example within which the medical and public community could operate in the future.

CONSOLIDATION

The County should restructure its present "health" related departments toward providing a system of health care services. The first phase would be the consolidation of the County's Public Health and Mental Health Departments, followed within five years by the eventual consolidation with the Valley Medical Center and, in order to develop a "human services" system, close cooperation with the Welfare Department and Probation Department. Restructuring should be predicated on a definition of health broader than the limited statement that "health is simply the absence of disease". There must be a reordering of priorities based on the development of imaginative strategy for achieving health goals under a broad definition of health--that being "the state of complete physical, mental, and social well being".

Should we continue to develop and rely heavily on complex medical technology for the treatment of acute or life threatening diseases or conditions, or would we be better advised to broaden our approach, devote more of our efforts to identifying, containing, or resolving the health problems that have major impact on the quality of our lives? The latter is more in tune with our times.

We should recognize that society has become increasingly concerned with the problems of living, the quality of life, the burden of disability, distress, and dependency. Consolidation of these two departments at this time and with the coordinated effort of the above mentioned departments toward additional future consolidation will point Fresno County in the general direction that health care is taking nationally today and which was discussed in the previous chapter.

Similarities of Public and Mental Health Departments

Consolidation of the Public Health and Mental Health Departments of Fresno County would not be difficult from either an organizational or philosophical point of view. Public Health and Mental Health have major goals for promoting health, preventing illness, early case finding, and rehabilitation of those who are already casualties. Both have offered much in the way of direct services, consultation, education, and information to the community. Basic concepts of providing health care by both departments, of responsiveness, accessibility, equity, and concern can be found throughout the history of both departments. Both provide primary care, outreach services, clinical services, public education, information, rehabilitative and consultative services, as well as multifaceted relationships with all hospitals, physicians, nursing homes, health related organizations and the community.

DECENTRALIZATION

The process of decision making, budget preparation, and deployment of personnel for health care services systematically exclude input from the social environment of the community or neighborhood. This local environment is intimately tied to almost all human problems, yet it is rarely considered when traditional services are being designed. Decentralization provides a means of moving the process down to the level where services are needed. Decentralization to the community and neighborhood level is imperative if we intend to involve consumer boards that accurately represent the community, to discover potential resources for human services hidden in each community, to involve citizens and providers in meaningful roles within the system, to reach a larger percentage of people experiencing problems and to develop local prevention programs. The delivery of present health services by Fresno County is done basically from the Kings Canyon medical campus. Exceptions to this are: (1) the Mental Health Outreach teams, which, to varying degrees, provide certain treatment and/or consultation services in the outlying communities of Selma, Sanger, Orange Cove, Del Rey, Clovis, Reedley, Firebaugh-Mendota, Coalinga, West Fresno, and Huron; (2) Public Health Nurse teams which provide a variety of services including community nursing services through home health agency, acute/chronic programs, maternal-child health programs, communicable disease control; and (3) Public Health clinics which provide services of: medical problems, maternity service, family planning services, and well child conferences at Huron, Firebaugh and Five Points.

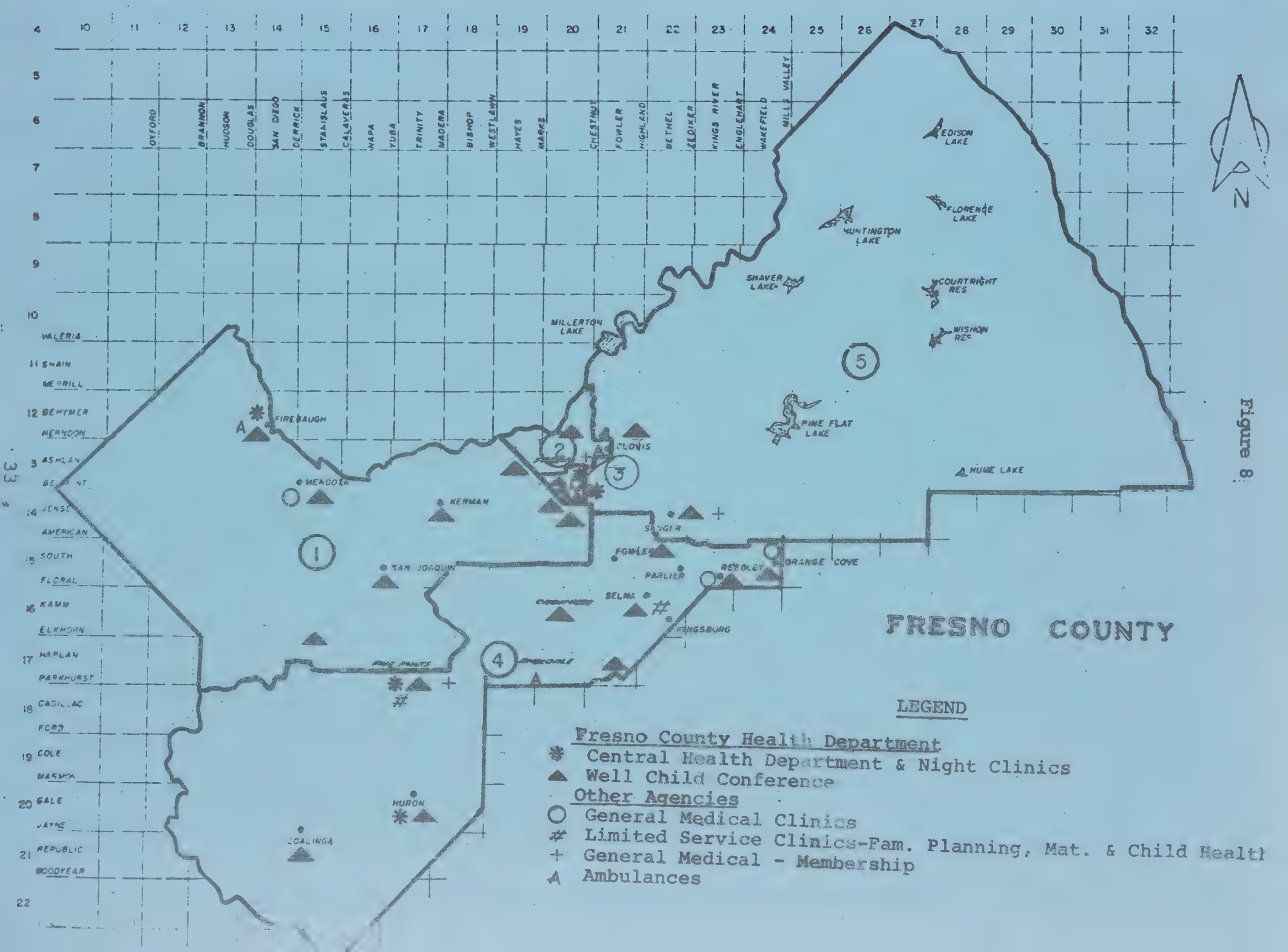

FRESNO COUNTY
LEGEND
Fresno County Health Department
Central Health Department & Night Clinics
Well Child Conference
Other Agencies
General Medical Clinics
Limited Service Clinics-Fam. Planning, Mat. & Child Health
General Medical - Membership
Ambulances
N
EDISON LAKE
FLORENCE LAKE
HUNTINGTON LAKE
SHAVER LAKE
COURTRIGHT RES
WISHON RES
MILLERTON LAKE
PINE FLAT LAKE
HUME LAKE
FIREBAUGH
CLOVIS
MENDOTA
KERMAN
SANGER
FOWLER
SAN JOAQUIN
PARLIER
REEDLEY
ORANGE COVE
SELMA
KINGSBURG
PINEDALE
FIVE POINTS
HURON
COALINGA
1
2
3
4
5
OXFORD
BRANHAM
HUDSON
DOUGLAS
SAN DIEGO
DERRICK
STANISLAUS
CALAVERAS
NAPA
YUBA
TRINITY
MADERA
BISHOP
WESTLAWN
HAYES
MARKS
CHESTNUT
FOWLER
HIGHLAND
BETHEL
KEDIKER
KINGS RIVER
ENGLEHART
WAKEFIELD
MILLS VALLEY
VALERIA
SHAIN
MERRILL
BEHYMER
HERNDON
ASHLAN
BE NT
JENSE
AMERICAN
SOUTH
FLORAL
KAMM
ELKHORN
HARLAN
PARKHURST
CADILLAC
FORD
COLE
MARMOR
GALE
JAYNE
REPUBLIC
GOODYEAR

Figure 8

The present delivery system of health-related services from a centralized facility is inequitable to the county's residents. Services provided by Public Health Nurses and Mental Health Outreach teams, and clinics are not equal in range to the services provided on the medical campus. In addition, there are two other problems which discourage the public:

--An inadequate public transportation system coupled with fuel shortages and threats of gasoline rationing will reduce, if not curtail, visitation to the medical campus by residents of the outlying communities.

--Unfamiliarity with the campus facilities and programs precipitates confusion and misunderstanding both among clients and county employees and reduces drastically the potential for developing an effective, integrated health care system.

Health Care Centers

A comprehensive community based health center ought to be the form in which health care services are provided to the community. The center should contain a full range of health services including medical, pediatric, maternity, mental health, and social services. It is proposed that the decentralized health care centers be placed in the five catchement areas, which would be similar to those of the supervisorial districts, thus giving them equal population and identity. This would not only allow for individual programs for each district area to be developed on the basis of community need, but would also provide for a political relationship between the individual supervisor and his district health care center, and the establishment of an advisory board which could relate to both the supervisor and the district health care manager. The orientation of the center would be toward entire families and would encourage the deliverers of health care services to think of the entire family both in a diagnostic and therapeutic sense. Being located in a neighborhood makes health services readily acceptable, not only physically but psychologically.

There exists a substantial amount of evidence which indicates that both consumers and providers are interested in the development of decentralized, primary care centers as a means: (1) to provide comprehensive services under one roof, (2) to expand entry into the health care system from a neighborhood setting, (3) to offer employment opportunities to local citizens to participate in the health care system, and (4) to humanize the health care process.

While specific health care center sites are not being proposed at this time, it is suggested that they would be located in the higher populated "need" areas of the county, such as Clovis,

Pinedale, the Kings Canyon campus, West Fresno, and Selma with their own individual outreach teams working the more outlying areas of the district and at the existing Kings Canyon medical campus. Services provided out of these district health care centers would be similar to those fragmented services presently provided by the various county departments, but would be provided now in a coordinated manner and would be divided into the following five basic areas: health testing, health care, preventive/maintenance, sick care, and outreach. Those functions will be defined in Chapter VI.

What Should Occur at the Primary Care Level

1. The patient enters the health care system and the route is charted for his easy movement onto more complex and specialized levels. In both the urban and rural areas, primary health care resources for this purpose are becoming increasingly scarce. The primary health care resources that do exist, whether in the form of private practitioners serving as primary physicians (general practitioners, internists, or pediatricians), or outpatient clinics or emergency rooms are characteristically oversoheduled and overcrowded. Patients under private care often must act as their own screening and referral agents; clerks or receptionists, many of whom lack adequate training, are frequently expected to act in this triage capacity for patients who enter through emergency facilities or through specialty oriented outpatient clinics.

2. Basic health care services are provided. At the primary care level, the patient should be able to receive a full spectrum of needed and desired basic services to maintain or restore him to a healthy or stable state, i.e. provision of education about health and disease, promotion of healthful living in a safe and healthy environment, provision of basic preventive, maturative and rehabilitative services, the management of long-term chronic disease and the provision of adjunctive and ancillary services, such as home nursing, homemaker services, transportation, pharmacy, and physical therapy. One crucial basic health care need that should receive special attention is crisis support. Human support services provided in past times by the extended family, the church, and other social institutions are now unavailable to large segments of the population. The primary health care system is in an exceptional position to provide continuing support and help during an emergency and periods of physical or emotional stress.

3. A mechanism is provided for continuing case management and coordination. For too long, the patient has been without anyone who continues to take responsibility in his behalf,

whether the patient is receiving adjunctive or related services, whether he is receiving most of his care from primary or specialized facilities, whether he is in bed or ambulatory, at home or in the hospital, someone must maintain surveillance over his overall progress. The health care system also needs a mechanism to integrate and coordinate medical care with sub-systems of dentistry and mental health. Someone must be responsible for seeing that the patient does not "fall into the cracks", that care given by all health providers is blended together, and that proper intervention--preventive or curative--is taken against the health problem at hand.

Team Approach

Functional consolidation and the establishment of integrated health care services would necessitate the creation of teams of health workers. This important benefit has to do with the practical implications of the exchange of insights between different disciplines which increase the chance of uncovering problems, as well as making diagnoses more accurately. A commitment to use teams of health workers to deliver coordinated, comprehensive family health care has been a persistent theme of neighborhood health centers developed by the Office of Economic Opportunity. Guidelines issued by OEO in February 1967 stated that "new ways should be sought to develop, train, and utilize a health team that would be innovative in both structure and function".

Experience has sensitized us to deficiencies in the health care system that health care teams providing comprehensive services can help overcome. In discussing this matter with those who are in the field, it was apparent to them that they have searched in vain for other services needed by their patients. We have witnessed repeatedly the chaos that ensues when patients receive their medical care from different sources, without the help of a coordinating mechanism built into the system, and the buck passing that occurs when the responsibility for the patient's well-being is not assigned to any one person or group. In both situations, we see the need for someone in the health care system who could relate closely to the family and mobilize services in its behalf. We also see the need to shift care from its emphasis on medicine to concern for total health care. All our experience has, therefore, propelled us toward the advocacy of a method by which coordinated augmented family health care can be administered. Health systems can be improved so that all persons serving a family have access to all necessary information. But simply obtaining and transmitting information is not enough. An organized way is also needed to define desired patient care outcome, to decide who is to do

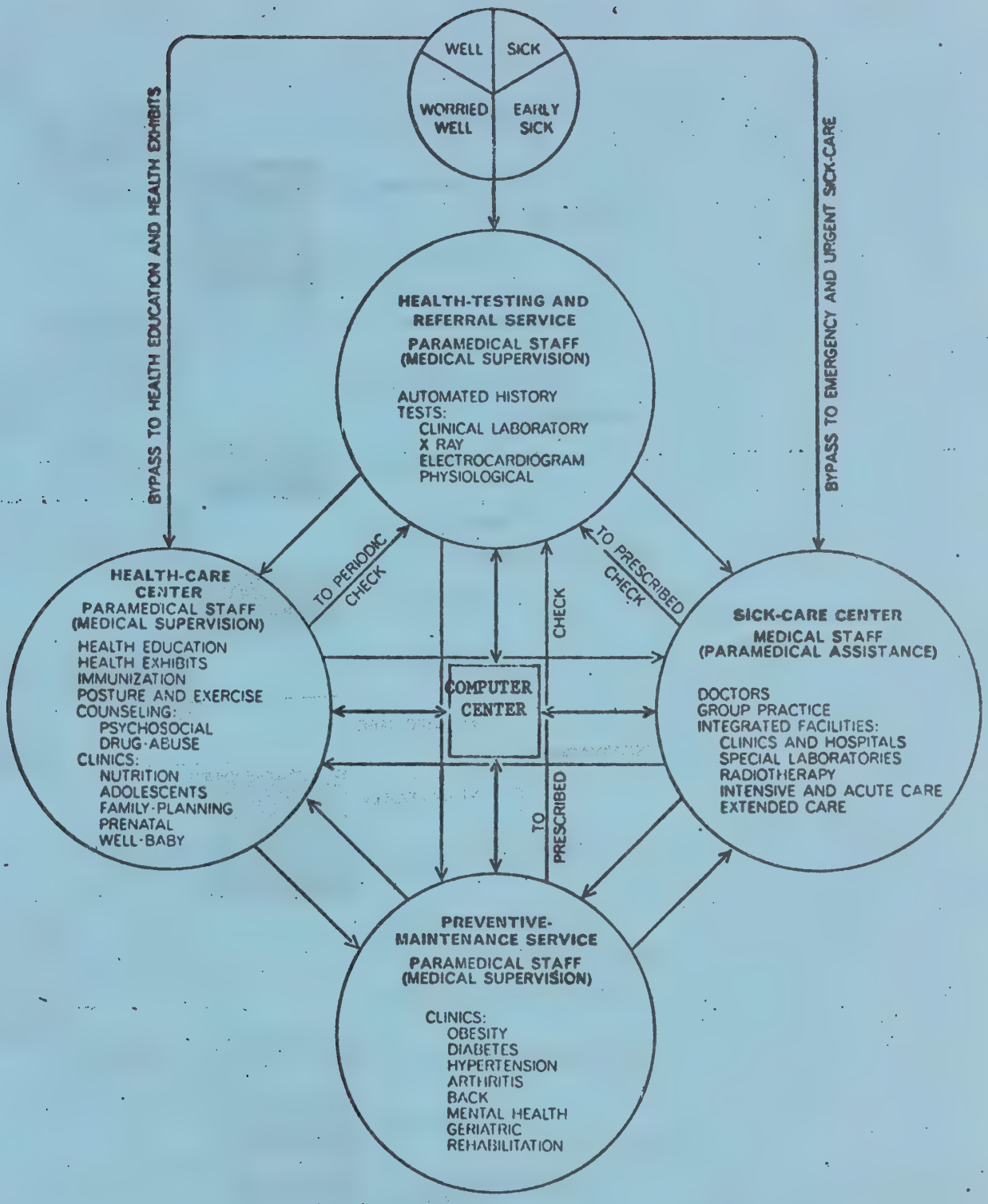
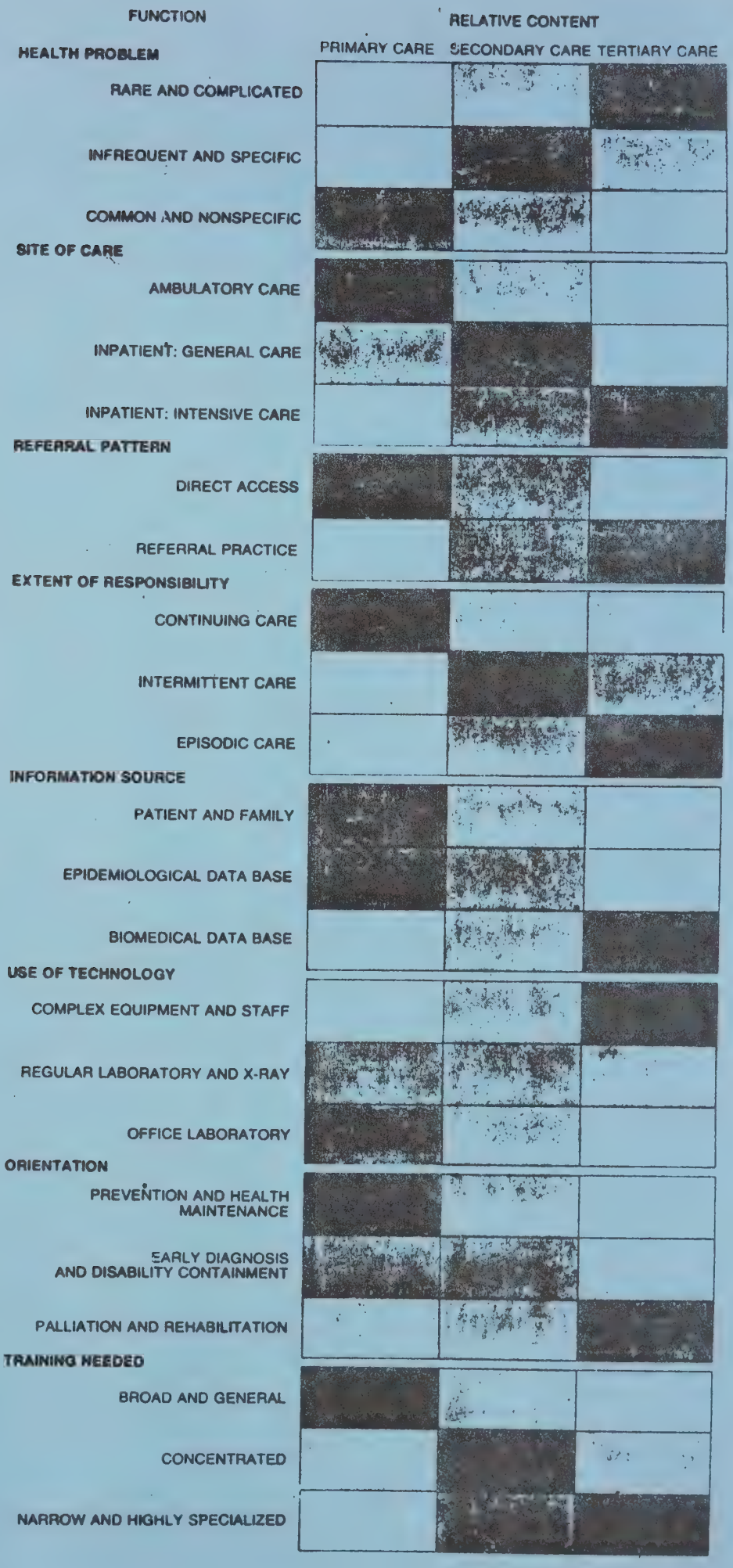


Figure 9

NEW DELIVERY SYSTEM proposed by the author would separate the sick from the well. It would do this by establishing a new method of entry, the health-testing service, to perform the regulating function that was performed, more crudely, by the fee-for-service. After health testing the patient would be referred for sick care, health care or preventive maintenance as required and would be transferred among the services as his condition changed. The computer center would regulate the flow of patients and information among the units, coordinating the entire system, which would depend heavily on paramedical personnel to save doctors' time.

Source: Garfield, Sidney R., "The Delivery of Medical Care", Scientific American, April 1970, Volume 222, Number 4, p. 22.

Figure 10



LEVELS OF MEDICAL CARE are characterized loosely in this illustration according to the relative importance of primary, secondary or tertiary care in dealing with a wide range of medical problems and functions. The more important the level of care, the darker the color in the appropriate box.

Source: White, Kerr L. "Life and Death in Medicine", Scientific American, September 1973, p. 33

what to achieve this outcome--to manage all necessary activities, to monitor progress, and to evaluate success. This organized system is synonymous with the team.

Another reason for teams

Presently, comprehensive care needs and the present structure of society make the delivery of health care by a single practitioner impossible. Why?

- First, there is the need for different skill levels. Optimal health care requires skills that range from the most elementary, such as turning or bathing a baby, to the most complex such as cardiac diagnosis. Because of spiralling health care costs and the inefficiency in the use of available resources, it is imperative that each person function in so far as possible in the highest level at which he is effective and that less exacting tasks be delegated to those with less training who also function at the highest levels for which they are prepared.

- Second, the need for different delivery sites. Health care must be delivered in a variety of sites if it is to be responsive to patient needs and if the patient is to receive comprehensive diagnosis, treatment, and support services. Although the decision about where care will be given depends primarily upon what is the best for the patient, it obviously must take into account what is feasible and realistic for the system. Some services, because they require special equipment and personnel, can be provided only in ambulatory or hospital facilities; others, because of manpower considerations, can be furnished only in centralized locations where patients can be seen during a scheduled period of time. Some, like assessment of the home environment or provision of home nursing services and "outreach" can take place only in the home. The need to deliver care at different sites contributes to the need for more than one person since it is necessary to keep travel time at a minimum and to schedule the use of facilities, each employee's work day, and each patient's time as efficiently as possible.

- Third, the need for different kinds of people because of social and cultural differences, as well as variations of age and sex between provider and patient groups; different kinds of persons are needed to relate to patients in different ways. The health care system, for these reasons, is in need of a person who can readily relate to the patient, speak his language, and get sufficiently involved to help the family work out its problems.

This person can epitomize the "caring" aspects of health services by furnishing the warm, personalized and ongoing support so seldom available from today's professional.

Summary

If a well structured and well functioning mechanism can be created, certain potential advantages can be offered to patients as well as the county. For the patient and his family:

1. Services may be more easily coordinated and not require shifting the patient from agency to agency.

2. A new continuing type of evaluation review of services offered can be set in motion that has the potential for enhancing the quality of care.

3. We can ensure the delivery of the most appropriate service at the best site by the most appropriate person.

4. The patient can more easily identify with those who have continuing responsibility for his care.

5. By increasing the rationality of task assignments, team delivery may eventually make comprehensive services less costly than they are under traditional systems.

Some of the potential benefits for the system and the county are:

1. A more effective and efficient continuous, cooperative effort by a stable group will be given.

2. Administrative control, including supervision, is more efficient.

3. The employee may derive greater professional satisfaction from working in a stable situation in which each member is supported by the whole team, is assigned tasks appropriate to his training and has more opportunity to increase his skills and their use than he would derive from working in the relative isolation of the traditional delivery system.

4. It is easier to relate the patient's health status to the total care he receives.

CHAPTER VI

CONSOLIDATION: THE ORGANIZATION

On July 1, 1973 the organization of the Public Health Department resembled the chart marked TO-1 on page 42 of this report. That organization had approximately 17 people reporting to the health administrator including 13 division heads. An analysis of that organization indicates numerous problems in integrating program and a meaningful health delivery system.

On that same date, the organization of the Mental Health Department is reflected in the chart marked TO-2 shown on page 43. With his appointment as Acting Director of Public Health, the Mental Health Director Dr. Trevor D. Glenn reorganized both departments for both administrative and functional reasons in an effort to provide a more effective role as the Director of the two departments. That structure is shown in TO-3 on page 44.

Consolidation of the two departments will require an integration of the various services and programs outlined in TO-3 and described in Chapters II and III of this report. Approval of consolidation, together with decentralization and the development of an integrated health care delivery system, will require substantial changes in the existing organization of the two departments. It is not felt that these changes can or should be made at one time. It is, therefore, proposed that they be phased in within a two year period in accordance with chart TO-4, as shown on page 45. It is felt that this phasing will be the least disruptive for both the organization and, more importantly, to the community, than would be possible if the reorganization took place entirely at one time.

The following is an explanation of the various divisions and their functions of the consolidated Health Department (as shown on TO-4).

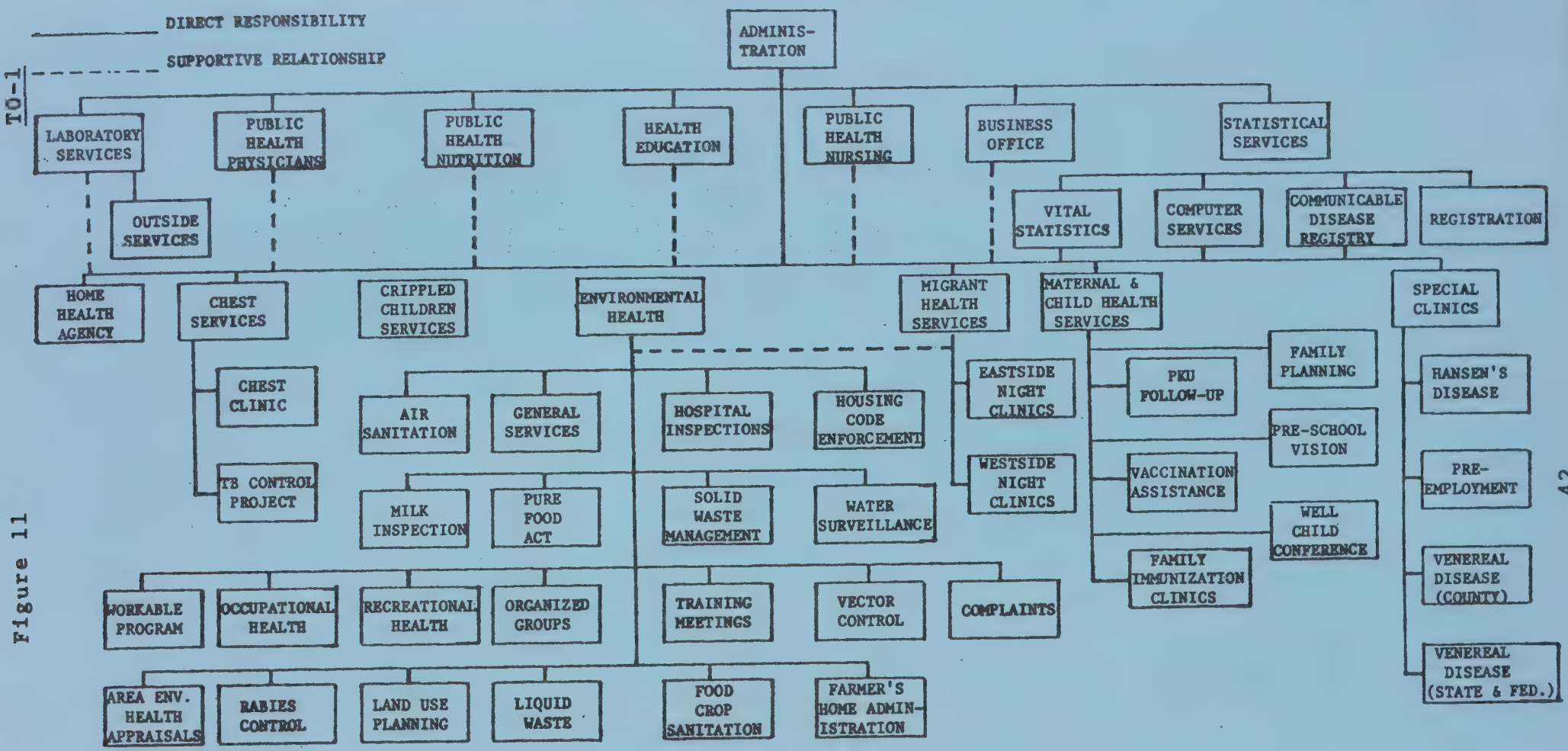
PRIMARY CARE

This division, headed by a Public Health physician, would be responsible through the five district offices for the delivery of primary health care. Each district would correspond to a supervisorial district and the district office would be placed at a site in a neighborhood of high population concentration and need.

DEPARTMENT OF PUBLIC HEALTH

CHART OF PROGRAM, PROJECT, AND SERVICE RELATIONSHIPS

July 1, 1973



TO-1

Figure 11

COUNTY OF FRESNO
DEPARTMENT OF MENTAL HEALTH
July 1, 1973

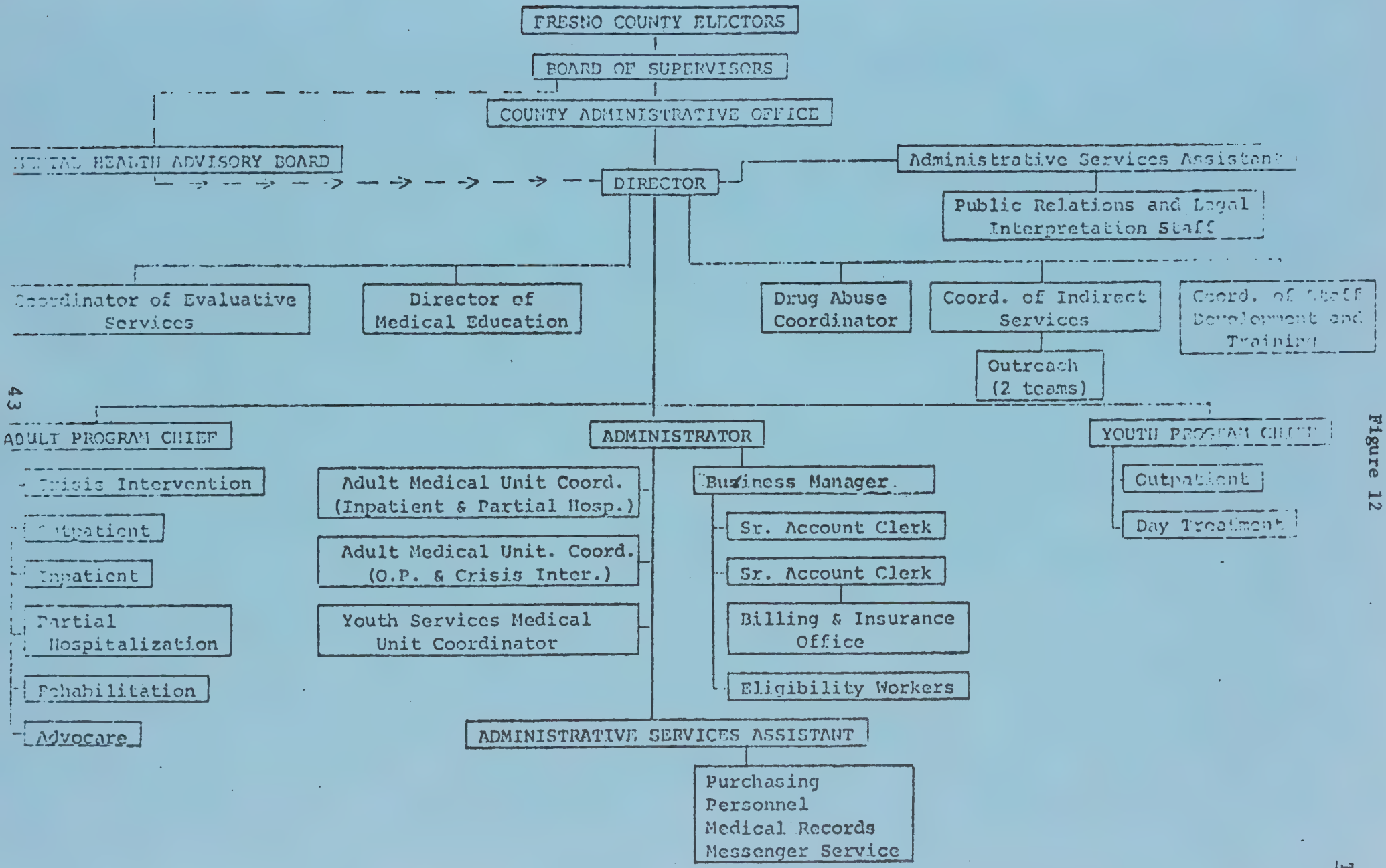


Figure 12

TO-2

Figure 13

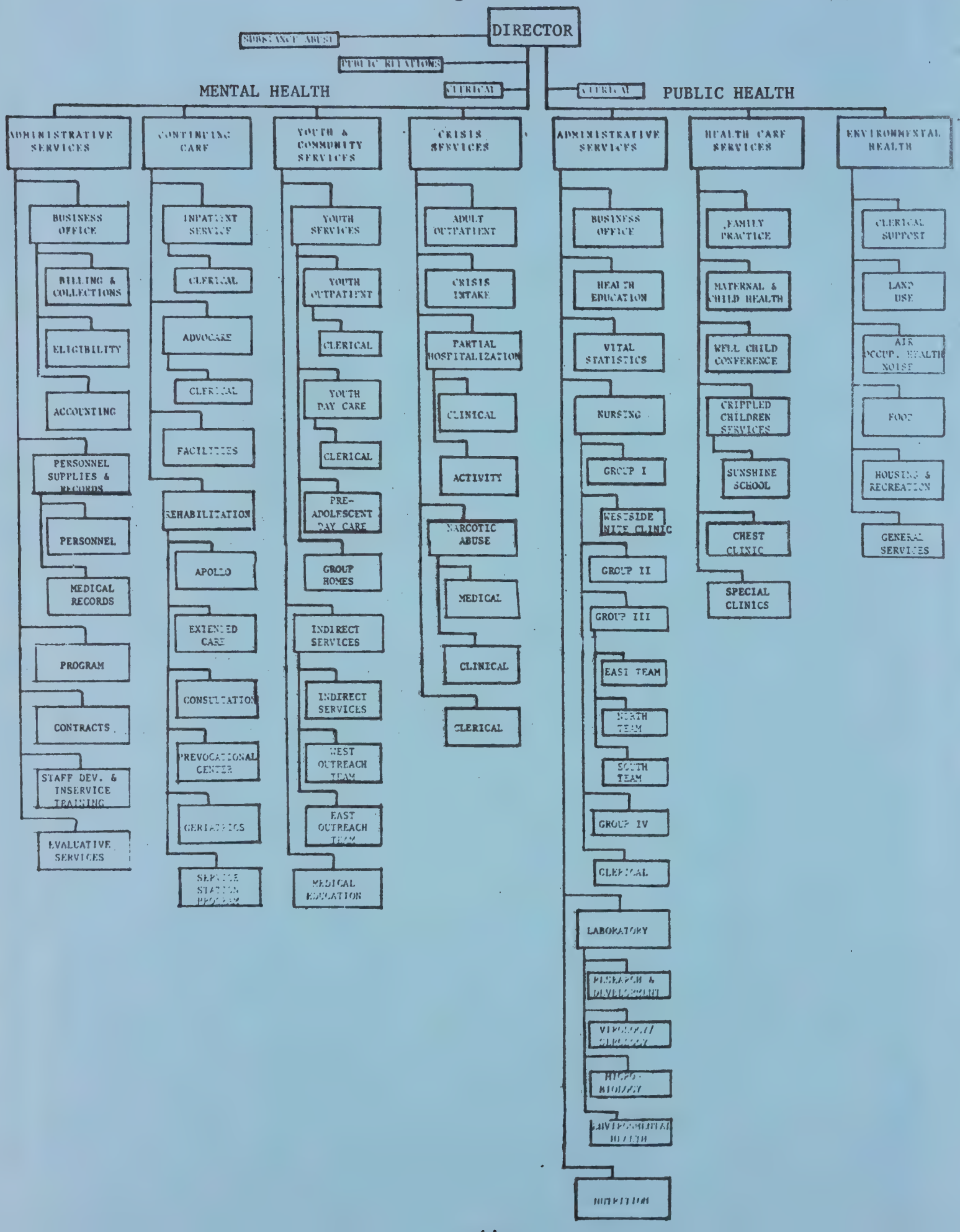
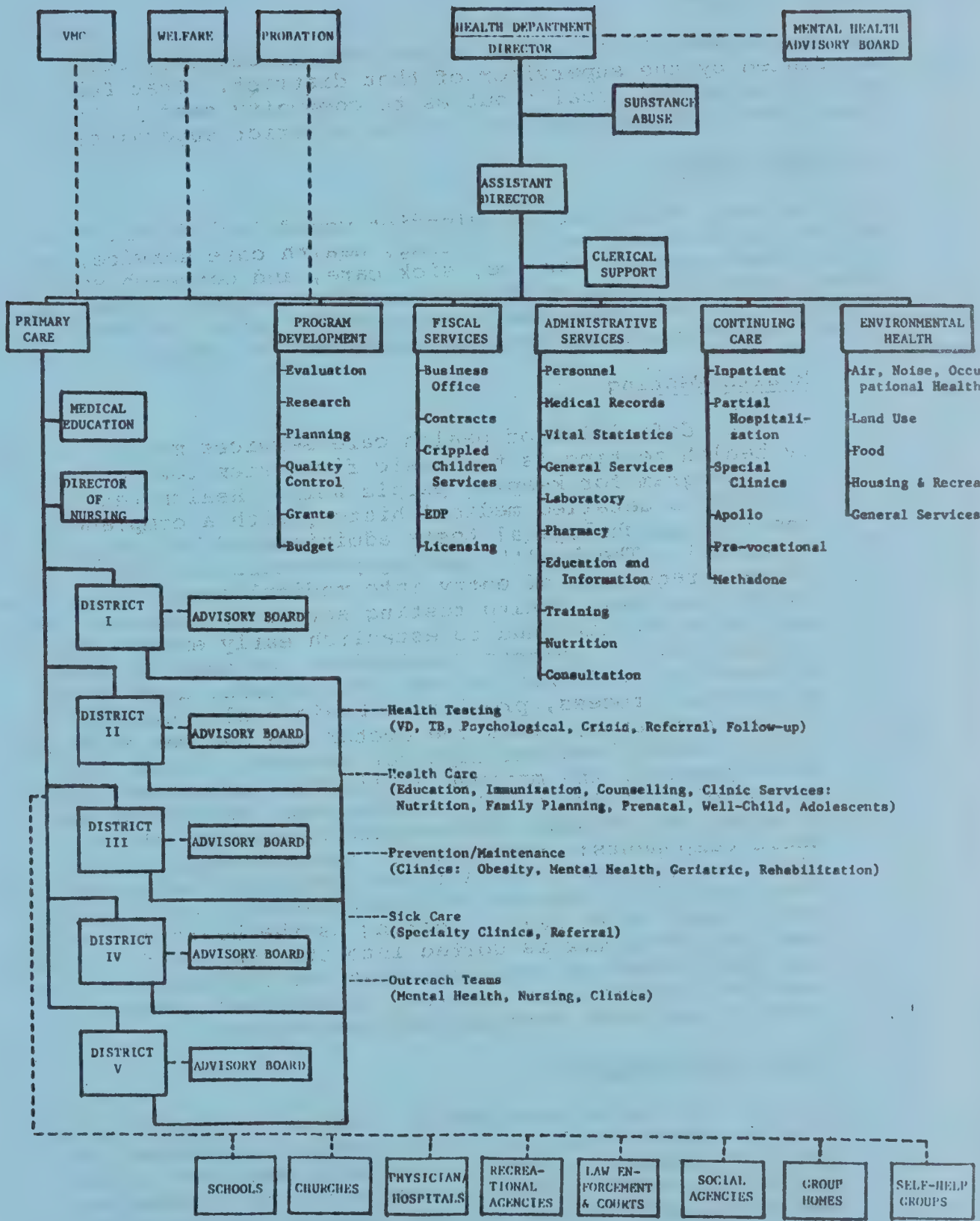

DIRECTOR
SUBSTANCE ABUSE
PUBLIC RELATIONS
CLERICAL
CLERICAL
MENTAL HEALTH
PUBLIC HEALTH
ADMINISTRATIVE SERVICES
CONTINUING CARE
YOUTH & COMMUNITY SERVICES
CRISIS SERVICES
ADMINISTRATIVE SERVICES
HEALTH CARE SERVICES
ENVIRONMENTAL HEALTH
BUSINESS OFFICE
BILLING & COLLECTIONS
ELIGIBILITY
ACCOUNTING
PERSONNEL SUPPLIES & RECORDS
PERSONNEL
MEDICAL RECORDS
PROGRAM
CONTRACTS
STAFF DEV. & INSERVICE TRAINING
EVALUATIVE SERVICES
INPATIENT SERVICE
CLERICAL
ADVOCATE
CLERICAL
FACILITIES
REHABILITATION
APOLLO
EXTENDED CARE
CONSULTATION
PREVOCATIONAL CENTER
GERIATRICS
SERVICE STATION PROGRAM
YOUTH SERVICES
YOUTH OUTPATIENT
CLERICAL
YOUTH DAY CARE
CLERICAL
PRE-ADOLESCENT DAY CARE
GROUP HOMES
INDIRECT SERVICES
INDIRECT SERVICES
WEST OUTREACH TEAM
EAST OUTREACH TEAM
MEDICAL EDUCATION
ADULT OUTPATIENT
CRISIS INTAKE
PARTIAL HOSPITALIZATION
CLINICAL
ACTIVITY
NARCOTIC ABUSE
MEDICAL
CLINICAL
CLERICAL
BUSINESS OFFICE
HEALTH EDUCATION
VITAL STATISTICS
NURSING
GROUP I
WESTSIDE MINI CLINIC
GROUP II
GROUP III
EAST TEAM
NORTH TEAM
SOUTH TEAM
GROUP IV
CLERICAL
LABORATORY
RESEARCH & DEVELOPMENT
VIROLOGY / SEROLOGY
MICRO-BIOLOGY
ENVIRONMENTAL HEALTH
NUTRITION
FAMILY PRACTICE
MATERNAL & CHILD HEALTH
WELL CHILD CONFERENCE
CRIPPLED CHILDREN SERVICES
SUNSHINE SCHOOL
CHEST CLINIC
SPECIAL CLINICS
CLERICAL SUPPORT
LAND USE
AIR OCCUP. HEALTH NOISE
FOOD
HOUSING & RECREATION
GENERAL SERVICES

Figure 14


VMC
WELFARE
PROBATION
HEALTH DEPARTMENT
DIRECTOR
MENTAL HEALTH ADVISORY BOARD
SUBSTANCE ABUSE
ASSISTANT DIRECTOR
CLERICAL SUPPORT
PRIMARY CARE
MEDICAL EDUCATION
DIRECTOR OF NURSING
PROGRAM DEVELOPMENT
Evaluation
Research
Planning
Quality Control
Grants
Budget
FISCAL SERVICES
Business Office
Contracts
Crippled Children Services
EDP
Licensing
ADMINISTRATIVE SERVICES
Personnel
Medical Records
Vital Statistics
General Services
Laboratory
Pharmacy
Education and Information
Training
Nutrition
Consultation
CONTINUING CARE
Inpatient
Partial Hospitalization
Special Clinics
Apollo
Pre-vocational
Methadone
ENVIRONMENTAL HEALTH
Air, Noise, Occupational Health
Land Use
Food
Housing & Recreation
General Services
DISTRICT I
ADVISORY BOARD
DISTRICT II
ADVISORY BOARD
DISTRICT III
ADVISORY BOARD
DISTRICT IV
ADVISORY BOARD
DISTRICT V
ADVISORY BOARD
Health Testing
(VD, TB, Psychological, Crisis, Referral, Follow-up)
Health Care
(Education, Immunization, Counselling, Clinic Services: Nutrition, Family Planning, Prenatal, Well-Child, Adolescents)
Prevention/Maintenance
(Clinics: Obesity, Mental Health, Geriatric, Rehabilitation)
Sick Care
(Specialty Clinics, Referral)
Outreach Teams
(Mental Health, Nursing, Clinics)
SCHOOLS
CHURCHES
PHYSICIAN/ HOSPITALS
RECREATIONAL AGENCIES
LAW ENFORCEMENT & COURTS
SOCIAL AGENCIES
GROUP HOMES
SELF-HELP GROUPS

ADVISORY BOARD

It is proposed that each district have an advisory board appointed by the supervisor of that district. That Board will provide the local input as to community need to both the district manager as well as the district supervisor.

DELIVERY SYSTEM

The delivery system of the district would include the functional services of health testing, health care service, preventive/maintenance service, sick care, and outreach services. This system would be an adaptation of Dr. Sidney R. Garfield's proposal and would be done in conjunction with the local physician services and hospital services, as needed.

Health Testing

A clear definition of health care services made possible by health testing is the basic first step toward a positive program for keeping people well. Health testing combines a detailed medical history with a comprehensive panel of psychological tests administered by paramedical personnel. The health testing procedure is ideally suited to be a regulator of entry into medical care and as a new entry regulator, health testing serves to separate the well from the sick and to establish early entry priorities. In addition, it detects symptomless and early illness, provides a preliminary survey for doctors, aids in the diagnostic process, provides a basic health profile for future reference, saves the doctor and patient time and visits, saves hospital days for diagnostic work, and makes possible the maximum utilization of paramedical personnel. Health testing, therefore, can effectively separate the present unstructured entry mix into its basic components: the healthy, the symptomless early sick, and the sick. This clear separation is the key to the rational allocation of needed medical resources to each group. With health testing as the heart of the system, the entry mix is sorted into its components, which fan out to each of the three distinct divisions of the service: health care service, preventive/maintenance service, and sick care service (see Figure 8).

Health Care Service

One of the health care service program's purpose is to provide educational and clinic services addressed to well populations. Services included would be health education, health exhibits, immunization, counseling services, and various clinics relating to nutrition, adolescence, family planning, prenatal, and well baby.

Preventive/Maintenance Service

The preventive/maintenance service would provide educational and monitoring services for individuals with previously diagnosed conditions who require periodic assessment/supportive care to maintain them at maximum level of functioning in their home setting. Services would include a variety of clinics relating to obesity, diabetes, hypertension, mental health, geriatric, and rehabilitation.

Sick Care

The purpose of the sick care service would be to provide acute or episodic health care services for those individuals who cannot be efficiently or safely served in the primary care centers. This service would be provided primarily by outside facilities including individual physicians, group practices, and integrated facilities such as clinics and hospitals (both public and private, including Valley Medical Center), special laboratories, radiotherapy, intensive and acute care, and extended care facilities.

Outreach Services

The purpose of the outreach program would be to provide those basic functions of the district office through multi-disciplinary health care teams in the more outlying areas.

Coordination with VMC

It is proposed that whenever possible staffing of the clinics relating both to family practice and specialty types be provided under contract by the physicians of Valley Medical Center. This coordination will have several advantages. First, clinics will provide necessary facilities for the medical training program at VMC. Second, the community will receive the benefit of these physician's services in an area closer to their home and away from the institution. Third, the Health Department will have greater flexibility in physician time, as well as not having to maintain a large physician staff.

Staffing of District Offices

It is impossible to say what the exact staffing requirements for each district office will be at this time. While the population areas will be similar, the staffing requirements will be determined on the basis of program and work load. There will, however, be the requirement of establishing an

administrative core to organize and supervise the district office. There will then be the areas of multi-disciplinary teams to handle the work load and programs. In addition, space in the center should be made available for representatives of the Welfare Department, Probation Department, Environmental Health and other human service related departments.

PROGRAM DEVELOPMENT

Program Development is the planning arm of the department. It has been said that the only thing constant in life is change, yet there is great variability to man's modes of adapting to change. The need to develop our ability to predict, plan and thus prevent reoccuring crises should have the highest priority. The lack of planning has created serious gaps between the purpose of our organizations and the degree to which they are effective in satisfying human needs. The proposed Program Development Division would have the following components: Evaluation, Research, Planning, Quality Control, Grants,and Budget Development.

FISCAL SERVICES

Fiscal Services division supervises the fiscal operations of the department including the functions of accounting, budget control, billing and collections, eligibility, financial counseling, internal auditing, contract development, negotiations, and monitoring administration of the crippled children's services, licensing of group homes, and EDP.

ADMINISTRATIVE SERVICES

The Administrative Services division will be responsible for the functions of personnel services, medical records, vital statistics, general services, including purchasing, inventory, storeroom, duplicating, and messenger service, laboration, pharmacy, and the functions of education, information, training, consultation, and nutrition.

CONTINUING CARE

Continuing Care division will be responsible for the centralized services of inpatient care, partial hospitalization, methadone, special clinics, and the socialization programs, including the Apollo and Prevocational Programs.

ENVIRONMENTAL HEALTH

This division will continue to provide its present services promoting good public health practices through education, inspection, and enforcement of health regulations. Services would include inspection of food, meat and milk products,

water supply, housing, hospitals and nursing and boarding homes, as well as control of liquid and solid waste disposal, communicable disease control, including rabies, vector control--insects and rodents, air pollution control, occupational health, consultation services, land use and development. Environmental Health division would assign one district sanitarian to each of the five district offices to participate as a member of the health care team. It would also be advisable that the division be moved back to the Kings Canyon medical campus as soon as physically possible.

THE ROLE OF OTHER AGENCIES

Valley Medical Center

As previously proposed, Valley Medical Center physicians should provide the medical staffing of clinics of the Health Department. The present centralized clinics provided by both VMC and the Public Health Department and similar in nature should be evaluated and a determination made as to which agency would be in the best position to provide that specific centralized outpatient service. All health care programs should be closely coordinated and paralleled as they relate to charges, forms, procedures, etc. Due to the number, type, and specialization of VMC outpatient clinics, the decentralization program should not have a detrimental impact on VMC.

Welfare

Including Welfare as part of the Health Care team and operating existing programs out of the district offices is not only advisable, it is mandatory if an integrated health care delivery system is to be developed. Functions of welfare including the initial application for aid, food stamps, medical needy, child welfare, and general relief programs, as well as all prescribed State social services can be handled out of the district office by Welfare staff.

Probation

Including Probation as part of the team in decentralized facilities is strongly supported by the County's Probation Officer. He sees the mission of the Department involved in intake, investigation, diagnosis, prevention and advocacy. Treatment should be provided by private agencies and other public departments. The Probation Department should also provide technical assistance, consultation, training resources and community support. Interplay between the various County departments previously mentioned and Probation can only add to the possibility of the Department's success in meeting its goals.

Personnel Requirements

While it is felt that consolidation will not require any additional positions, it is difficult to determine, at this time, what the effect of the proposed consolidation will have on future personnel requirements (increases as well as decreases) of the department. Factors affecting that determination are:

1. Two year time frame to complete consolidation.
2. Decentralization of program.
3. Present physical space limitations.
4. Increased work load due to decentralization.
5. Changes in existing programs.
6. New programs.

Health Department Annexation Building

There has been approved in the 1973-74 County Revenue Sharing budget an amount of $4,711,000 for the construction of an annexation to the present Public Health building. Construction of that facility was held up pending the completion of this study and changes in space needs required by consolidation. While it is felt that this office building will still be required, the specific use of the building, its function, and its inhabitants will be dependent upon the Board's position regarding consolidation, decentralization, and the future integration of a human services program. It is estimated that once those decisions are made, space needs can be developed within 90 days, architectural changes ordered and construction of facility commenced. Completion of the building will take approximately 2½ years from the date of the Board's decision.

Phasing

As stated previously in this report, consolidation of the two departments should be accomplished through the process of phasing. Initial functions to be consolidated would be the Administrative Services functions of both departments. It is estimated that staffing requirements, system changes, and physical relocation could take place within the next 90 days. At the conclusion of that consolidation, attention should be given to bringing together the nursing and outreach program functions of the two departments, with a goal of completing that phase within 90-120 days. Phase 3 would require the development of district site locations for Board approval and the acquisition of necessary facilities at those locations and initial staffing. It would be proposed that phase be completed

by January, 1975. Phase 4 would call for the movement of staff from the central medical campus to the various sites based upon initiation of the program and work load requirements. Completion of that phase would be by the end of the calendar year. Phase 5 would call for the transfer of the Environmental Health Division back to the medical campus when space is available.

Additional Revenue

An analysis of the revenue accounts of both departments leads one to the conclusion that the Public Health Department is not taking full advantage of its potential sources of revenue. Excluding Crippled Childrens Services, which is 100% offset, the department's revenue toward its costs is only 17%. It is felt that increases in fees for clinical services can take advantage of Medi-Cal, private, and third-party payor revenues available to the department without inhibiting client requests for service. In addition, in the area of Environmental Health, there are a variety of functions presently being provided free to the public for which there could be a charge. Totally, there appears to be the potential for developing revenue sources in an amount of at least 30% of expenditures. Recommendations regarding new and increased charges will be submitted to the Board of Supervisors in the near future.

CHAPTER VII

CONCLUSION

It has been the attempt of this report to explain: the need for changes in the organization and delivery of public services in County Government; the requirements and present functions of the County's Public Health and Mental Health Departments; the changing health care delivery system through consolidation; decentralization, establishment of health care centers, a team delivery system, and a greater effort toward prevention; and finally, the consolidated organization which will carry out the policies and programs of the Board of Supervisors.

The Future Outlook for Delivery of Human Services

The need for changing the existing method of delivery into an integrated system is not just a dream, it is fast becoming a reality and one that will be sponsored by the Federal Government. On July 25, 1973, Department of Health Education and Welfare Undersecretary Frank C. Carlucci spoke before the National Association of Counties in Dallas, Texas on the subject of the "Delivery of Human Services." The following is based upon his remarks at that meeting.

> "The taxpayers of this country spend around $126 billion for human services provided by the Federal Government alone, but both those who pay for these services and the intended recipient are far from getting $126 billion worth of good out of them. The root cause of this is simply that we do not have one human service network but hundreds of narrowly based health, education, welfare, and manpower programs operating in virtual isolation from one another.
>
> Sixty percent of the people who seek social services are turned away. Of the 40 percent who actually get in an agency's door, only 17 percent actually get served. And that is only one measure of the system's failure. In addition, 9 of every 10 people who walk through the door of a human service agency need not only one service but a number of services.
>
> For instance, a disadvantaged teenage girl who gets pregnant needs at least 10 services--prenatal medical care, nutrition guidance, guidance on being a parent, continuation of her regular high school education, obstetric and pediatric care when her baby is born, vocational education, job placement

assistance, day care for her child so she can work, family planning help to avoid unwanted future pregnancies, and so on. If she fails to get even a few of these services, the odds strongly favor her becoming a "regular" on the Aid to Families and Dependent Children rolls. In fact, about 80 percent of our nation's AFDC rolls consist of women and children in fatherless homes.

We have calculated the odds of a person getting all the services that he needs, and those odds come out to a flat zero.

Or you can turn the human-need equation around the other way. Say that a person only needs one service to become self-sufficient. Say that a man needs job training but does not get it. This single agency's failure can set off a chain reaction. The man has to go on welfare. Or he steals and ends up in jail. If he does not get vocational training in jail, he is still headed down the pipe and is using up public agency resources all the way. He may become a chronic offender, using up more police and more court resources. He may become an alcoholic or a drug user--using up still more agency resources. Now he is a one-man epidemic of human service needs. Meanwhile his family is using up public resources like there was no tomorrow--and for them there is none. This futile, endless consumption of public resources can happen because an initial human service need was not met. That is today's human resources delivery system--or nonsystem. This system is wasting human resources at a colossal rate and with few exceptions it is not working."

"The problems have come about largely because of a failure to plan comprehensively and to share governmental responsibility. The nonsystem we have today is in pieces because that is the way it was legislated into existence--piece by piece.

Every time some element of human need was recognized--public housing, food stamps, day care, veterans' pensions, or whatever--Congress was implored to pass a law, and it did.

This narrow-purpose categorical aid legislation accumulated slowly until 1960. Then the dam broke. In 1960 we had around 200 Federal aid programs. Today we have more than 1,000.

There is no way to coordinate from Washington the hundreds of Federally aided programs that operate in a single county. Some coordination has been done at the grassroots. But even with the best efforts to coordinate at the grassroots, the chances of success are not great. Too many Federal laws and too many regulations separate these programs from one another. And when you separate programs, you separate the people in charge of them, and that fragments the service to the people in need."

It seems apparent that we in Fresno County are in a position both legislatively and administratively, in the health care field at least, of making the necessary philosophical and organizational changes to put together an integrated health care delivery system which, to the people it serves, will be both responsible and responsive.

TABLES

Table 1

FRESNO COUNTY DEPARTMENT OF MENTAL HEALTH

Types of Services	JULY 1969 JUNE 1970 LPS Became Effective	JULY 1970 JUNE 1971 Change in Philosophy Reduce Inpatient Incr. Crisis Intv.	JULY 1971 JUNE 1972 Implemented New Building	JULY 1972 JUNE 1973 Service Emphasis Changed from Inpt. Days for Few Pts. to Outpt. Serv. for Many Pts.
OUTPATIENT:				
Crisis-Intake	---	---	6,501	8,129
Adult	17,128	20,647	16,338	15,901
Rehabilitation	968	2,923	4,688	6,916
Youth	8,696	11,170	12,145	14,934
Outreach	---	---	770	2,987
Advocare	---	---	---	4,092
SERVICES	26,792	34,740	40,442	52,959
DAY TREATMENT:				
Adult	5,090	5,350	9,245	11,739
Youth	---	---	1,139	6,600
DAYS	5,090	5,350	10,384	18,339
INPATIENT:				
Acute	12,357	12,352	6,089	5,433
Fig Garden (Chronic)	---	---	500 (Approx.)	7,627
DAYS	12,357	12,352	6,589	13,060
INDIRECT:				
Consultation, Educ. & Information	1,299	1,402	3,316	13,406
Training	---	---	2,816	6,515
HOURS	1,299	1,402	6,132	19,921
TOTAL UNITS Local Programs	45,538	53,844 (+18%)	63,547 (+18%)	104,279 (+64%)
NET COST Local Programs	$1.088 M	$1.787 M (+64%)	$1.931 M (+8%)	$2.361 M (+22%)
STATE HOSP. DAYS	73,451	48,742 (-34%)	25,377 (-48%)	1,845 (-93%)
NET COST	$1.314 M	$1.226 M (-7%)	$751,483 (-39%)	$30,570 (-96%)
TOTAL NET COST	$2.402 M	$3.013 M (+25%)	$2.682 M (-12%)	$2.391 M (-11%)
TOTAL UNITS OF SERVICE	118,989 Units (62% S.H. Units)	102,586 Units (48% S.H. Units)	88,924 Units (-13%) (29% S.H. Units)	106,124 Units (2% S.H. Units) (+19%)
AVERAGE NET COST/UNIT	$20.19	$29.37 (+45%)	$30.16 (+3%)	$22.53 (-26%)

PMT:br

January 31, 1974

Table 2

FRESNO COUNTY DEPARTMENT OF PUBLIC HEALTH
STATISTICAL COMPARISON

	1960	1965	1970
CLINIC ATTENDANCE			
Chest Clinic	20,678	6,834	38,053
Night Clinic [d]	d	11,193	15,257
Pre-Employment Clinic	b	560	1,103
Venereal Disease Clinic	3,567	3,785	4,475
Child Health Conference	14,623	16,011	15,437
Family Immunization Clinic	Not Available	Not Available	27,464
Crippled Children's Service	438	452	261
Family Planning Clinic [a]	a	a	44,679
Total	39,306	38,835	146,729
ENVIRONMENTAL HEALTH VISITS	20,206	19,881	36,490
PUBLIC HEALTH NURSE VISITS	15,463	42,241	44,679
CRIPPLED CHILDREN'S THERAPY	6,284	7,977	3,329[c]
LABORATORY			
Specimens	32,257	35,190	39,928
Procedures	73,483	72,349	80,049
POPULATION	368,500	403,900	414,200
BIRTHS			
Number	9,011	7,991	8,044
Rate/1,000 Population	24.45	19.78	19.42
DEATHS			
Number	3,039	3,279	3,694
Rate/1,000 Population	8.25	8.12	8.92
NATURAL INCREASE			
Number	5,972	4,712	4,350
Rate/1,000 Population	16.20	11.66	10.50

a = Clinic began in 1966

b = Clinic began in 1963

c = Short on Therapists

d = Clinics became Health Department responsibility in 1963

Division of Statistical Services
JLM:ib 2-1-74

Table 3

FRESNO COUNTY POPULATION

SELECTED CHARACTERISTICS

by

SUPERVISORIAL DISTRICTS

1970

PERVISORIAL DISTRICT	PERCENT COUNTY POPULATION	ESTIMATED* POPULATION	PERCENT POPULATION UNDER 5	PERCENT POPULATION OVER 59	PERCENT POPULATION BLACK	PERCENT POPULATION SPANISH SURNAME	PERCENT FAMILIES BELOW POVERTY INCOME LEVEL
1	20%	82,610	10.2	11.6	21.5	37.2	26.8
2	20%	82,610	7.9	8.4	0.8	12.9	6.8
3	20%	82,610	8.0	20.1	2.0	20.8	13.2
4	20%	82,610	9.1	13.6	1.7	37.8	17.7
5	20%	82,610	8.0	12.5	1.1	23.3	11.8
TOTAL	100%	413,053	8.6	12.9	4.9	25.2	14.2

* Does not add to totals

SOURCE: U.S. Bureau of Census
Census of Population and Housing
Census Tracts
Final Report PHC (1)-75, Fresno California
SMSA

Division of Statistical Services
JLM:ib 12-7-73

Table 4

VALLEY MEDICAL CENTER OUTPATIENT CLINICS

Gynecology-Obstetrics
- Endo-Infertility
- General GYN
- GYN-GU
- Initial Pre-Natal
- Interval Pre-Natal
- Post Natal
- Tumor
- Special OB
- EAB
- Dysplasia

Family Practice
- Family Practice Model Clinic

Medicine
- Allergy
- Cardiology
- Cardiac Pacemaker
- Dermatology
- Endocrine
- General
- GI
- Medical Referral
- Hematology
- Neurology
- New Medical
- Pulmonary
- Renal/Hyper Consult
- Rheumatology
- Spinal Puncture

Pediatrics
- Ped Specialties

Orthopedic Surgery
- General

Surgery
- Dental
- ENT
- General
- GU
- Hand Plastic
- Minor
- Neuro Surgery
- Ophthalmology
- Proctology
- Surgery C
- Vasectomy

Miscellaneous
- Audio
- Spec. Services